Maternal and Child Health Services
Title V Block Grant

State Narrative for Kentucky

Application for 2009
Annual Report for 2007

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.
An attachment is included in this section.

C. Assurances and Certifications

Assurances and Certifications for the Title V, Maternal and Child Health Block Grant are on file in the office of the Division of Adult and Child Health Improvement. 502-564-4830.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input for the Title V Block Grant is accomplished in several ways.

The Department for Public Health submits two copies of the Title V/Maternal and Child Health Block Grant application to the Legislative Research Commission (LRC) of the Kentucky General Assembly after the grant submission each July.

A public hearing is scheduled annually, during July, prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is provided. A news release is sent from the CHFS Office of Communications to media within the state announcing the date and location of the public hearing. Title V staff are in attendance and are available for questions at each hearing. The FY 07 public hearing was held July 5, 2006. There were no comments. Kentucky is seeking new avenues to obtain public input including web-based access.

/2008/ The Interim Joint Committee on Health and Welfare held a public hearing on the Title V/Maternal and Child Health Block Grant on September 20, 2006. Department for Public Health Deputy Commissioner, Dr. Steve Davis, provided the Committee with an overview of the Maternal and Child Health Block grant and the programs and services provided.

The FY 08 public hearing was held Friday, July 13, 2007. There were no comments. Kentucky is seeking input from parents and stakeholders through a variety of program advisory councils and workgroups. The MCH Stakeholders survey is also a tool used to seek public input and is part of Kentucky's on-going needs assessment process. //2008//

/2009/ The Interim Joint Committee on Health and Welfare held a public hearing on the Title V/Maternal and Child Health Block Grant on August 19, 2007. Department for Public Health Commissioner, Dr. William Hacker spoke with Title V Director, Dr. Ruth Ann Shepherd and Commission for Children with Special Health Care Needs Executive Director, Eric Friedlander available for questions. The Health and Welfare Committee was

provided with an overview of the Maternal and Child Health Block grant and the programs and services provided.

A link to the Title V/Maternal and Child Health Block Grant is on the Department for Public Health Website.

The FY 09 public hearing was held Tuesday, July 15, 2008. There were no comments. //2009//

Parents are well represented on the Interagency Coordinating Council and TA teams for First Steps, the Newborn Screening Advisory group and the Early Childhood Council led by the Dept for Education.

The Commission assures family and consumer input to program development by including two parent representatives and one young adult patient representative on the 7-member Board of Commissioners. Families and patients are also represented on the Commission's Hemophilia Advisory Committee and on a volunteer advisory committee for the Universal Newborn Hearing Screening program. All these groups receive regular program updates and have the opportunity to provide consultation and work with the Commission on various committees or workgroups throughout the year. Information about the Block Grant performance measures are shared with these advisory groups.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In 2006, based on Kentucky's rising rate of preterm birth, the Division of Maternal and Child Health analyzed data related to prematurity. We compared our preterm birth rate with several surrounding states and found we had the highest preterm birth rate of any of our contiguous states. Analysis of our birth certificate data included such factors as medical risk conditions, age of mother, births from assisted reproductive technology, multiples, C-section and vaginal deliveries by gestational age. This analysis identified the late preterm infant as the primary factor in our rising preterm birth rate. This analysis was one of the factors which led to our selection for the prematurity prevention initiative "Healthy Babies are Worth the Wait" with National March of Dimes and Johnson & Johnson (Corporate contributions division) as partners.

In 2007 (2008 Title V application), State Performance Measures were deleted or revised for clarity and to assist Kentucky to concentrate fully on our goals of improvement. For FY 2008, Kentucky has deleted 2 State Performance Measures (#3 and #6) due to their similarity to National Performance Measures. Another State Performance Measure (#5), "Decrease the rate of Birth Defect Specific Infant Mortality in Kentucky" was also deleted because any new progress would be difficult to measure. Deleting these Performance Measures allows Kentucky to provide a renewed and sharpened focus to the National Performance Measures and the remaining State Performance Measures. State Performance Measure #4 was revised to focus on Medicaid eligible pregnant women and the oral health care they receive during pregnancy. Medicaid eligible children and oral health is the focus of Health Systems Capacity Indicator #7B. State Performance Measure #7 was revised to address preconceptual services for all women of child-bearing age.

For 2009, Kentucky requested and received Technical Assistance regarding Needs Assessment from MCHB. A Title V Needs Assessment Technical Assistance Meeting was held on March 24, 2008 led by the team from the University of Chicago, College of Public Health: Michelle Issel, Deb Rosenberg, Arden Handler, and Joan Kennelly.
This TA provided an overview of needs assessment elements, a review of process models, examples of other states with good processes, and a discussion of Kentucky's capacity and issues. An action plan was developed which included a logic model and timeline. Based on this TA, planning for the comprehensive 2010 needs assessment is underway and will include both qualitative and quantative data, from existing sources and new sources of information. The goal is to identify needs from the level of communities as well as the overall state picture.

III. State Overview

A. Overview

Geographic

The Commonwealth of Kentucky is very diversified with changing topography including fertile fields in the West used to support agriculture, to the Appalachian Mountain Range in the East used to support lumber and coal industries, to the Bluegrass or Central region of the state which is world renowned for its thoroughbred horse industry. There are two major cities, Louisville and Lexington with both cities containing major universities, the University of Louisville and the University of Kentucky, with medical and dental schools, Schools of Public Health, research activities, and teaching facilities that support public health initiatives. These two universities are also affiliated with the two major tertiary care hospitals providing specialized services. A third medical school, the Pikeville School of Osteopathic Medicine, is located in far eastern Pike County. Other universities with Schools of Public Health include Eastern Kentucky University (Richmond), and Western Kentucky University (Bowling Green). Eastern Kentucky University is more focused on Environmental Health and Community Health Education. Other Universities are supportive of Public Health including Kentucky State University (Frankfort) and Northern Kentucky University in Ft. Mitchell, Kentucky.

Kentucky has 120 individual counties varying in geographic size, population, income/poverty and educational attainment. These vary from the small Eastern Kentucky county of Robertson (pop. 2,266 in 2000) to Jefferson County (pop. 693,604 in 2000). Key areas still remain isolated and distant from major cities, universities and health care services. The Eastern Kentucky Coal Field is the primary region falling into this category. Due to the mountainous areas with winding and narrow roads, residents may drive for several hours to reach a main interstate artery.

The far eastern portion of the state consists of 51 counties that are a portion of the Appalachian region. Compared to other areas of the state, residents in eastern KY have lower income and education levels and have higher rates of many health problems. The Appalachian population is approximately 1,145,000 and is dispersed over 17,714 square miles. Nearly 70% of Appalachians live at or below the federal poverty level. Additionally, only 62% of adults in Appalachia have completed high school, compared to the statewide average of 74%, and the national average of 80.4%. In 2004, the Appalachian Regional Commission reported that Appalachians as a minority group are characterized by significantly high rates of poverty, substandard housing, high unemployment rates, and discriminatory attitudes about their culture. Many of these areas have a shortage of health care professionals, resulting in little or no access to primary health care and a heavy reliance on regional hospitals and medical clinics. Because of the small populations in many counties, county-specific health data is difficult to obtain and may have questionable accuracy when available. This means that regional data is often the only information available to health professionals planning interventions and assessing need. ***/2009/ The planned National Children's Study has NO sites in the 51 county Appalachian region, so needed data for this high risk area will not be collected from that study. //2009//***

Demographic

Kentucky's total population is 4,041,769 according to 2000 Census figures. During the past decade, Kentucky's population grew by 356,473 persons, a growth rate of 9.7 %. This places Kentucky 25th among states in population. During the previous decade, Kentucky's population grew by only 7 %. Kentucky's rate of live births has also steadily increased; from 52,054 in 1995 to 55,147 in 2003; an increase of 6%.

Disparities persist in Kentucky. Only 8.7 % of the total births in 2004 were classified as African-American. In the Louisville/Jefferson County area, Kentucky's largest urban area, the African-American population comprised 18.9 % of the total county population (for a total of 130,928

citizens) in 2000, yet this accounted for 44 % of the entire African-American population in the Commonwealth of Kentucky. Other counties with substantial African-American populations (as a portion of the total population in the state) in 2000 include Fayette (12%), Christian (6%), Hardin (4%) and Warren (2.7%).

2000 Census data also shows that the Hispanic population in Kentucky is growing rapidly, with an increase of 172.6 % over 1990 Census totals. The Hispanic population nearly tripled from 20,363 in 1990 to 59,939 in 2000. This figure, of course, does not take the illegal population into account, which is thought to be a substantial number. This data reports counties with the largest Hispanic population are also Jefferson (12,370), Fayette (8,561), Hardin (11,178), Christian (3,494), and Warren (2,466). In 2004, the population estimates showed the Hispanic population to be 77,055, an increase of 6 % over the previous year, predominately in those counties mentioned. In 2005, the Hispanic population increased by another 6%.

Patient data for children enrolled in the Commission for Children with Special Health Care Needs reflects the growing Hispanic population and comparatively low numbers of other immigrant populations. A data snapshot of the Commission's population taken on June 30, 2006 showed the following distributions among the 8,862 active enrollees, 78% white; 8.2% Black/African American; 4% Hispanic; 3% Other; less than 1% Asian, less than 1% Native American/Alaska native and less than 1% Native Hawaiian/Pacific Islander. Of these same 8,862 active enrollees 8,472 listed English as their preferred language and 256 individuals listed Spanish as the next highest preferred language. Sign language continues to rank third, Bosnian 4th. Other language preferences include Albanian, French, German, Russian, Somolian, etc. CCSHCN is experiencing an increase in the percentage of Hispanic clients.

/2009/ Based on 2007 Census estimates, Kentucky's total population is 4,241,474. Since 2000, this represents an increase of 28%. Births in Kentucky in 2005 total 55,990, which is a 1.5% increase from 2004. The African American population remains stable at about 8.7% of Kentucky's total population. Based on population estimates from 2006, the Hispanic population in Kentucky is 85,938, which is an increase of 5% from the previous year. For 2006, the counties with the highest Hispanic populations are: Jefferson (18,352), Fayette (14,375), Warren (3,510), Shelby (3,235), and Hardin (3,113). Total Hispanic females in 2006 in Kentucky are estimated to be 36,673 and 2,509 are infants. //2009//

Socioeconomic Indicators

Socioeconomic indicators for Kentucky's population vary widely. A few of the key indicators are reviewed below for Kentucky. Data is supplied by 2000 County Health Profiles, produced by the Kentucky State Center for Health Statistics, Kentucky Department for Public Health.

Rates of Medicaid Eligibility and Use: In 2002, 20.6% of the population of Kentucky was Medicaid eligible. Owsley County ranked highest in Medicaid eligible percent (59.6%) and Oldham County ranked lowest (5.6%). Statewide, of the 20.6% eligible for Medicaid, only 20.4% of those individuals actually used Medicaid services. Medicaid Utilization ranges from a high in Owsley County (59.3%) to a low in Oldham County (5.7%).
In 2003, 21.1% of the Kentucky population was eligible for Medicaid. Owsley County ranked highest in Medicaid eligible percent (60.2%) and Oldham County ranked lowest (6.0%). Of those eligible in the state, only 19.7% utilized services for Medicaid. Utilization range from a high in Owsley County of 56.5% to a low in Oldham County of 6.1%. However, utilization of medicaid for children was much higher - see HSCI 07A.

Food Stamp, AFDC, and WIC Recipients: These measures present data on the proportions of the population who accessed programs for the indigent. In fiscal year 2000, 10.0% of the total population received food stamps, 3.4% received AFDC benefits, and 8.8% of the population was served by the WIC program. Owsley County ranked highest in food stamp percent (40.7%), Wolfe

County, highest in WIC percent (20.3%), and Owsley County, highest in AFDC percent (14.6%).

Median Household Income: In 1999, the median household income for Kentucky was $33,732. There has been a slow but steady increase: in 2001, the median household income increased 6.65% to $35,977; In 2005, the median household income increased 3.87% for Kentucky to $37,369 in 2005.

Persons in Poverty: Based on 1999 statistics, 15.8% of the population in Kentucky were below the poverty level, a decrease from 17.9% in 1995. Kentucky counties ranged from 33.7% in Owsley County to 5.0% in Oldham County. It is estimated that one-fifth (20.2%) of the total population under the age of 18 lived in poverty in 1999, a marked decrease from 26.0% in 1995. Wolfe County was the highest in this measure at 44.8%. This has shown little change; by 2004, 15.0% of the overall population in Kentucky were below the poverty level. Individual Kentucky counties with significant population below the poverty level ranged from 32.2% in Owsley County to 5.8% in Oldham County. For the population under age 18, Kentucky showed no change in the population living in poverty from 21.2% in 1999 to 21.1% in 2004. For individual counties, Owsley County continued to be the county with the highest population under 18 living in poverty at 47.3%.

Unemployment Rate: The unemployment rate in December of 2002 was 5.4 %, an increase over the previous year. This ranged from a high in Taylor County of 15.5% as a result of the closing of the Fruit of the Loom plant several years ago to a low in Jessamine County of 1.5% (an affluent suburb to the south of Fayette County).

Educational Status: The educational status of both men and women is closely related to socioeconomic status and also has implications for health, as women are key to the provision of health care in most families. In 2000, the educational status of mothers remained steady with one in five (21.4%) of Kentucky women with less than 12 years of education. This measure ranged from 43.7% in Clay County to 6.9% in Oldham County.
From 2001 to 2004, the educational status of mothers did not show a significant change from 21.2% to 21.1% of Kentucky women with less than 12 years of education. Women with less than 12 years of education ranged from 41.0% in Crittenden County to 8.2% in Oldham County. Todd County, which was the highest county in 2001, improved from 40.9% in 2000 to 31.1% in 2002. //2008//

/2009/ Despite a progressive increase in median household income in Kentucky ($39,372 in 2006), data for the year 2005 also show an increase in the percent of Kentuckians in poverty (16.9%). The county with highest poverty percent was still Owsley (45.5%) and the lowest percent was Oldham (5.8%). For those under 18 in poverty, 23.0% of the state fell into this classification, which was an increase. The increases are reflected in the entire range of county rates; the highest percent of children in poverty was Owsley (61.9%) and the lowest was Oldham (5.8%), both increases from previous years.

The latest data on education (2005) show that 20.3% of Kentucky mothers had less than 12 years of education. This is slightly decreased from previous years. Clinton County was the county with the highest percent of mothers with less than 12 years of education (40.0%) and Lewis County was the county with the lowest pecent (5.9%). //2009//

Access to Primary Care

Kentucky's predominately rural nature, with almost 50% of Kentucky's population living in rural areas and 98 of its 120 counties categorized as non-metropolitan, means that successful health care recruitment to this population is particularly important for the health of the state. Access issues are still a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in Kentucky, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area. The Kentucky Department for Public

Health allocates that majority of the Title V funds to local health departments for the provision of primary care regardless of an individuals ability to pay.

In 2004, there are 41 Geographic HPSAs and 33 low-income HPSAs in Kentucky. There are also 15 dental HPSA designations and 96 counties identified as Mental Health HPSAs. In 2007, only 9 of 120 counties (7%) did not have at least part of the county designated as HPSA or MUA. There were 304 HPSA's and 148 MUAs in Kentucky.

/2009/ As of July 2008, there are 143 Primary Care HPSA's, 56 Dental HPSA's and 202 Mental Health HPSA's distributed across the 120 counties in Kentucky. There are 167 Medically Underserved Areas/Populations in Kentucky as well. These shortage area designations will provide the counties with an opportunity for better recruitment and retention of providers through programs such as the National Health Service Corps and J1 Visa Waiver Programs. The designations also enables the county to participate in Rural Health Clinic Programs and Federally Qualified Health Center Programs that serve the low income and uninsured. //2009//

Organizations that are active in addressing access as a priority healthcare concern in the Commonwealth include the Kentucky Primary Care Association, the UK Center for Excellence in Rural Health, Pikeville College School of Osteopathic Medicine, the Foundation for a Healthy Kentucky and the University of Kentucky, College of Medicine.

The Kentucky Primary Care Association was founded in 1975 as a private, non-profit corporation of community health centers, rural health clinics, primary care centers and other organizations and individuals concerned about access to health care services for the state's underserved rural and urban populations. There are currently 18 Section 330 Health Centers operating in Kentucky. These organizations receive funding to help offset some of the cost for providing care to low income uninsured patients.

Kentucky has 18 primary care sites that receive federal funding and operate through licensed primary care centers and rural health clinincs; and these have approximately 58 service locations including a mobile van in 35 underserved counties of the state. The importance of primary care is more widely recognized and Primary Care centers cover all of the life stages - prenatal, pediatric, adolescent, adult and geriatric. In addition to offering primary care services, other services offered at these locations include: Dental, Mental Health/Substance Abuse, OB/GYN, Pharmacy, Other Professional Services and Specialty Care. The affordable, accessible, comprehensive and continous nature of primary care makes it a vital element to the health care services provided in Kentucky. Formal linkages and collaborative efforts between primary care centers and local health departments vary throughout the state. In 2005, 224,183 individuals received services in the Primary Health Centers. Three Primary Health Centers focus their services toward the homeless and seasonal/migrants farmworkers.

The UK Center for Excellence in Rural Health in Hazard, Kentucky is one of the FQHC's and was established in 1990 to address health disparities in rural Kentucky, including a chronic shortage of health professionals and residents' poor health status. The center accomplishes this through health professions education, health policy research, health care service and community engagement. Nearly 80 percent of the center's graduates are practicing in rural areas, most of them in Kentucky. The center houses the North Fork Valley Community Health Center, the host clinic for the East Kentucky Family Medicine Residency Program. The center also houses the Kentucky Homeplace program and Kentucky State Office of Rural Health, which are nationally recognized for improving rural residents' access to health care.

The Pikeville College School of Osteopathic Medicine opened in 1997, becoming Kentucky's third medical school. The mission of the school is to provide family and primary care physicians for Kentucky and Central Appalachia, where there is a severe shortage of primary care practitioners. More than 93% of graduates enter primary care residencies, and 79% of graduates are serving in

underserved areas. About half the students are from Kentucky, and another 35-40% are from other Appalachian states, which makes them more likely to serve in rural areas. The PSCOM partners with the Kentucky Oral Health Program to provide oral health education to faculty, students, interns, and residents there. The ultimate objective is to improve the oral health status of Kentuckians, especially pregnant women and children.

The Foundation for a Health Kentucky is a non-profit, philanthropic organization working to address the unmet health care needs of Kentuckians. Their approach centers on developing and influencing health policy to promote lasting change in systems by which health care is provided and good health sustained, to: Improve Access to Care, Reduce Health Risks and Disparities and Promote Health Equity.

/2009/ The University of Kentucky College of Medicine will begin training in Fall 2008 to as many as 10 medical students to work in rural communities. The Rural Physicians Leadership track will spend 2 years at the medical college in Lexington and 2 years at Morehead State University in Eastern Kentucky. In addition to the medical school curriculum, students will learn other business skills needed to establish a medical practice in a rural setting. In addition, the UK College of Medicine is partnering with the UK Dental School to develop a network of rural centers for a translational research network, which should also enhance the capacity and access to dental care and other services in areas where there is little available. //2009//

Department for Public Health - Mission

As mandated under KRS 211.005 the definition of core public health was specified at the beginning of the chapter on public health laws. This statute mandates that the Department for Public Health develop and operate all programs for assessing the health status of the population, for the promotion of health and for the prevention of disease, injury, disability, and premature death. Services provided by the Department for Public Health and all local health departments include: enforcement of public health regulations, surveillance of public health, communicable disease control, public health education, implementation of public health policy, efforts directed to population risk reduction, and disaster preparedness. This identification by statute fosters the development of the role of the Title V agency to provide a comprehensive approach to health. The Department for Public Health, in conjunction with the Title V program, provides preventive clinical services in circumstances where providers are not available.
E-Health

The Department for Public Health is working on a number of infrastructure activities. One is to establish Kentucky as a leader in E-Health. This is also a primary issue of Lt Gov Mongiardo. The E-health Board was created by the previous Governor but will continue with this administration. The Department for Public Health Commissioner, Dr. William Hacker, chairs this important board,as well as e-health committees for ASTHO. The Department for Public Health has taken the first step towards an electronic public health record with a web-based system for hospitals to enter birth certificate and newborn screening data. This system is called KY-CHILD. This system was rolled out to all birthing hospitals in Kentucky in December 2006, and it provides one-time entry of basic demographic data for all children born in the Commonwealth including: vital statistics data (live birth certificate), newborn metabolic screening data and hearing screening data. Immunization data will be the next module to be implemented. This system enhances the follow-up capabilities of the newborn metabolic screening programs. In addition, it has facilitated the development of quality assurance reports for all birthing hospitals. Prior to KY-CHILD, all of this reporting was completed manually with data entry. This web-based system minimizes the possibility of errors within the data, minimizes the discrepancies between data formats and significantly improves the timeliness of data availability. The Cabinet for Health and Family Services recently received an American Council for Technology (ACT) Intergovernmental Solutions Award for the KY-CHILD system.

/2009/ Another infrastructure initiative is moving Kentucky Department for Public Health towards Accrediation, both at the local and state level. A number of committees are actively working with national technical assistance to develop a system for Kentucky and prepare Kentucky's local and district health departments for accreditation. //2009//

Kentucky's Public Health Challenges in Maternal and Child Health

Challenge: Prematurity and Low Birth Weight
Prematurity and Low birth weight continue to be a challenge for Kentucky's mothers and infants. Data from Kentucky Vital Statistics, Live Birth Certificate Files show that in 2003, 8.5 % of Kentucky's infants are born weighing less than 2,500 grams and 1.7 % were born weighing less then 1,500 grams (very low birth weight). Preterm births (defined as live births at less than 37 weeks gestation) have risen from 12.5 % in 1998 to 14.0 % in 2003. The percentage of preterm births by race also varies significantly. From 2001- 2003, 19.1% of black infants were born prematurely as opposed to 13.1% of white. This data was further analyzed to determine the cause of the rising rates in Kentucky - see State Performance measure number 8. In 2005, preliminary data from Kentucky Vital Statistics shows that 8.8% of Kentucky's infants are born weighing less than 2,500 grams and 1.5% were born weighing less than 1,500 grams. Preterm births have risen from 12.5% in 1998 to 15.0% in 2005.

Kentucky has several groups collaboratively addressing prematurity through professional education and dissemination of new information about preterm birth. Through a long-established relationship with the Greater Kentucky Chapter of the March of Dimes Birth Defects Foundation, public and private health professionals are learning more about the causes and health outcomes of low birth weight and prematurity. The 2002 Maternal and Child Health Conference, reaching more than 700 health professionals throughout the state, focused on prematurity; inviting Dr. Jennifer Howse, President of the March of Dimes National Foundation as the Keynote Speaker. Dr. Howse called health professionals to action and unveiled the national March of Dimes Prematurity Campaign effort. Throughout the next one and one half days, many breakout sessions discussed specific aspects of prematurity; from the suspected link to oral health infections to racial and ethnic disparities in preterm delivery.

The Kentucky Perinatal Association (KPA) has highlighted Prematurity as the main theme of their annual education conference for the last 3 years in cooperation with the March of Dimes campaign. This conference is attended by physicians, nurses, social workers, dieticians, and others working in the field of perinatology.The Kentucky Perinatal Association 2005 Annual meeting presented a "Summit on Prematurity 2005", June 5-7, 2005 at Lake Cumberland State Resort Park. Topics included within the Summit agenda include "Newborn Metabolic Screening for KY 2005" by Joe Hersh, MD; "Domestic Violence and Substance Abuse" and "Update on Prematurity Research and National March of Dimes" by Karla Damus, MSPH, PhD, RN; "Maternal Perinatal Nutrition" by Diane Sprowl, RD; "In-vitro Fertilization and Advanced Reproductive Technologies" by Jon Cohen, MD; "Perinatal Loss" by Jeannette Osbourne, RN; and "Smoking Environment: How Far to Go?" by Kim Yolton, PhD.

/2007/ The 2006 Summit on Prematurity was held June 4-6, 2006 at Lake Cumberland Resort Park. Featured speakers and course topics included; HPEP Course Exposition (see below) by Henrietta Bada, MD; Diabetes During Pregnancy by Tom Tabb, MD; New Approaches to Prenatal Care (Centering) by Wendy Hansen, MD; "The Prematurity Problem: Kentucky Data" by Ruth Ann Shepherd, MD; The Infant Born at 36 Weeks is Still Pre-term by Eric Reynolds, MD; "What happens after the Preterm Infant Goes Home?" by Henrietta Bada, MD; Metabolic Screening: "When You Care Enough to Send the Very Best" by John Morrison, MD; and the HANDS Program: Impact on Preterm Birth in Kentucky by Joyce Robl, MS, CGC.

KPA has also developed an innovative web-based professional education program called the Health Professional Education on Prematurity (HPEP) course. The course offers free

CMEs/CEUs for participants and covers the major physiologic pathways to preterm birth. As of June 5, 2006; more than 520 professionals had taken this on line course, including some from as far away as California. In 2006, the Kentucky Perinatal Association was given an award from the National Perinatal Association for the outstanding innovation for the HPEP program. //2007//

The March of Dimes state chapter also hosts an annual Prematurity Summit each Fall. The 2006 Summit featured Dr. Charles Lockwood, whose description of pathways to prematurity has become the basis for much of the prematurity research. The 2007 KPA Summit on Prematurity was held June 3-5, 2007 with approximately 150 in attendance. The focus was the Late Preterm Infant and Tonse Raju, MD, Medical Officer for the National Institute of Child Health and Human Development (NIH) was the keynote speaker. Workshop topics include "Improving Outcomes through Maternal Nutrition," "Raising Awareness of Prematurity," "Decision Making for 36 Week Preterm," and "Scope of the Problem of Late Preterm Births." Also on the agenda was a panel discussion: "Healthy Babies are Worth the Wait: A Prematurity Prevention Partnership." The focus was Kentucky's demonstration project to address prematurity with DPH, March of Dimes and the Johnson and Johnson Pediatric Institute.

/2009/ The March of Dimes Greater Kentucky Chapter Prematurity Summit for 2007 attracted a crowd of nearly 300 people. The March of Dimes hosted the Summit on Prematurity in Louisville on November 2007. Topics included an overview of Prematurity in Kentucky, the Late Pre-Term Infant, Depression in Pregnancy, and Getting Help for the Pregnant Substance Abuser. Speakers included Dr. Ruth Ann Shepherd, Dr. Lucky Jain, Sheila Ward, and Carol Strange.

The emphasis of this conference focuses on issues related to high risk pregnancies and premature deliveries as well as care of the premature baby. The 2008 Kentucky Perinatal Association Summit on Prematurity was held on June 1-3 with approximately 150 in attendance. Topics included "Developmental Care for the Preterm Infants", "Follow-up High Risk and Premature Infants for Public Health Nurse and Other Health Care Professionals", and "Challenges for Obstetricians in Preventing Late Preterm Birth". The Keynote address, "Regionalization of Perinatal Care -- Then, Now, and the Future" was presented by Dr. Ruth Ann Shepherd and Dr. Eric Reynolds. Additional topics included, "The Best of the Guidelines in Perinatal Care" and a presentation of "Healthy Babies Are Worth The Wait", which is Kentucky's own initiative to prevent "preventable" preterm birth in partnership with the March of Dimes and the Johnson & Johnson Pediatric Institute. //2009//

Challenges: Smoking in Pregnancy
According to the CDC, Smoking during pregnancy is the single most preventable cause of mortality and morbidity in mothers and babies in the US. Kentucky has nearly the highest rate of smoking in pregnancy of any of the states. Birth certificate data reported that the number of women who smoked during pregnancy remained fairly constant (27% in 1991 to 23.4% in 2003). Kentucky changed to the new birth certificate beginning in 2004, which reports smoking in pregnancy differently. However, those reports are consistent, indicated we still have 26.7% of pregnant women smoking in the last trimester, and likely throughout pregnancy. ***/2009/ The MCH team is currently developing and implementing several projects to address this important health need-- see also National Performance Measure 15. //2009//***

Challenges: Health Disparities
In Kentucky the rate of the infant mortality is nearly twice as high in African-Americans as in Non-Hispanic white. In 2005, the black Infant Mortality rate rose to 15.0%, although overall Kentucky's Infant Mortality remained at 6.8% Prematurity and Low Birth Weight are also much higher in the African-American population: Preterm birth in blacks is 19%, whites 13.5% (2004). This is of great concern, even though Kentucky's population is only 8% African American.

The Dept for Public Health is developing the infrstructure for a statewide FIMR program. The program will follow National FIMR guidelines and will work closely with the Louisville Metro Health Department FIMR project and Healthy Start program. The Louisville Metro area contains the largest center of African-American population in the state. Other sites will be selected according to a PPOR analysis.

/2009/ The Bluegrass Farmworker Health Clinic (BFHC) provides services to the ever growing Hispanic population of seasonal migrant workers. BFHC opened a second clinic in Lexington, Kentucky on March 1, 2008.

For the Hispanic migratory and seasonal farm laborers in central Kentucky and just as many family members, language and cultural barriers are no longer an obstacle to primary health care, thanks to the Bluegrass Farmworkers Health Center. The Center consists of two facilities to serve migrant and seasonal farm workers in Madison, Fayette, Garrard, Jessamine, Woodford, Bourbon, Clark and Scott counties.
"We want to provide quality primary health care in a culturally competent manner with language support," said Dr. Susan Fister, program director and an associate professor of nursing at Eastern KY University. "I see this as a comfortable, embracing environment for them to receive medical care, a place where they know they'll encounter people who speak their language." All Center staff members are bilingual. According to Fister, about 70 percent of the migrant farm laborers speak no English, and only about 15 percent speak it well.

Because the Center's prospective clients are not covered by Medicaid/Medicare, the maximum charge for those seen by a nurse practitioner is a $10 co-payment. The fee is waived for those clients unable to pay. Those in need of dental, laboratory, pharmacy or radiology services are referred to the Center's contracted providers. Besides routine primary medical care, the Center also provides preventative care, such as family planning, TB screenings and blood pressure checks, and health education. //2009//

The Louisville Metro Health Department (LMHD) Healthy Start (HS) Program is a federally funded initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to project areas with high annual rates of infant mortality; the program focuses on the contributing factors which research shows influence the perinatal trends in high-risk communities. The program will pilot in three Louisville Metro communities, with some of the highest infant mortality rates in KY. The three neighborhoods, Bridges of Hope, Northwest and Ujima, are communities that have also been awarded a $1,275,00 Healthy Start, Eliminating Disparities in Perinatal Health program grant, based on the high infant mortality rate in those areas as well as other factors. The data for 2002 indicates the following: the infant mortality rate for the USA is 7/1000 live births, 7.2 for Kentucky and 8.9 for the Louisville Metro area. The infant mortality rate for the white population of the Louisville Metro area is 6.8 and for the African American population it is 15. The infant mortality rates for the three targeted Healthy Start communities, which are mostly African American, is Bridges of Hope 12.5, Northwest 15.4 and Ujima 24.2. The program has 5 core service interventions: a) direct outreach; b) case management; c) health education; d) interconceptional care; and e) screening for depression. The required core interventions are provided according to national Healthy Start guidelines. The Healthy Start program has been able to demonstrate improved birth outcomes in this disparate population. For example, Healthy start participants showed Decrease in the frequency of low birth weight births to African American mothers from 15.37% in 1996-1998 to 7.1% in 2003. The program also shows lowered infant mortality, although the numbers are small.
Healthy Start continues to target African American pregnant clients; by 2004, 89% of the clients were African-American.

The Division of Women's Health is applying to establish an Office of Minority Health.

Challenges: Oral Health

Kentucky has the dubious distinction of being the #1 state for toothlessness. Among our children, nearly half have untreated early childhood caries. Kentucky has a great need for dentists, particularly dentists who will see Medicaid children and pregnant women. A number of initiatives are addressing these issues.

Surveillance: A survey conducted in 2000-2001 resulted in enlightening data on the oral health status of Kentucky's school children. Kentucky's 2001 Children Oral Health Survey showed that nearly one-third of a sample of 2-4 year olds were affected by early childhood caries (ECC). 30% had severe ECC, 39% had never been to a dentist and 35% of their parents had not seen a dentist in the last year. Of these children, 39% had Medicaid, 15% had KCHIP and 29% had private dental insurance. When school-aged children (3rd and 6th graders) were surveyed, 57% had caries experience with 29% having visible decay, 51% reported bleeding gums and 15% had signs of gingival inflammation. 20% reported having a toothache in the past month and had not seen a dentist in the last year. Only 29% of these children had sealants on any molar. ***/2009/ Attempts to repeat this surveillance study have so far been unsuccessful. //2009//***

Fluoride Varnish Program:
Kentucky has 99% of public water systems fluoridated. However, that has not been enough to protect our children. The fluoride varnish program for preschoolers and a sealant program for school-age children both began in July 2003. By 2007, over 1400 nurses at local health departments, the Commission for Children with Special Health Care Needs and various others have been trained to do dental screenings and fluoride applications. Approximately 2000 children per month are receiving treatments through the Healthy Teeth for Tots program.

Dental Sealant Program:
The dental sealant program for school-aged children also began in July 2003. Local health departments screen children and develop agreements with local dentists to provide dental sealants.

State Dental Plan:
The Strategic Planning Process has been a collaborative effort between the Kentucky Department of Public Health and the University of Kentucky School of Public Health Dentistry. The process began with a selection of over 200 key players throughout the state to be a part of the planning process. This listing was eventually culled down to approximately 125 participants who participated in a six-question electronic survey (a SWAT Analysis) which asked for input on the strengths and weaknesses of the provision of oral health services in Kentucky; identification of additional factors that would have a positive (and negative) impact on the achievement of oral health and a vision (ideal state) for oral health. These questions generated many responses which have been condensed and provided the Oral Health Strategic Planning Executive Committee with a baseline from which to develop draft vision, mission, plus-delta and value statements. A copy of the plan is attached to this section. //2007//

/2008/ Regional Dental Centers:
Regional dental treatment centers will be established throughout Kentucky to provide service availability for children and adults alike. Several partnerships are already in place to make these centers of care a reality including Hazard and Morehead (Eastern Kentucky) and Madisonville (Western Kentucky). With improved access to care, specialized programs for all populations will be developed in our state. This series of programs and assessment tools, will have a positive impact on the oral health of Kentucky's children.
Three regional dental treatment centers (Hazard, Madisonville, Morehead) are operating with access to safety net care, clinical research (diabetes and oral health in Morehead, oral health and preterm babies in Madisonville, and obesity and oral health in Hazard) and community oral health promotion and education for dental school residents. The centers see adults, children and others who have no access to care as well as individuals with special needs (systemic diseases that

affect their oral health and the obverse).
Kentucky's Primary Care Centers are also providing dental services on a limited basis. Efforts continue through the KOHP to engage more primary care centers in the provision of comprehensive dental services. //2008//

Kentucky's Public Health Successes in Maternal and Child Health

While many public health challenges face Kentucky's health providers, there have been some exciting success stories over the past decade in Kentucky.

KIDS NOW Early Childhood Initiative (2000).
During the 2000 State Legislative Session, a radical new program called "KIDS NOW!" was introduced. "KIDS NOW!" is a comprehensive plan that addresses issues for children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through age 5, including child care. This program added $50 million new dollars to programs centered on children in Kentucky, and in excess of $30 million dollars was allocated specifically for programs dealing with maternal and child health. Funded through the national Master Tobacco Settlement, Kentucky's legislature passed a bill that allowed 25% of this funding to be directed to children and families; thereby assuring significant and ongoing support for this population. Outcome Measures for KIDS NOW! are many of the current MCH Block Grant Performance Measures, including universal newborn hearing screening, oral health, immunization status, low birthweight, births to teens and child safety.
The Vision of this Early Childhood Development Initiative was all young children in Kentucky are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthen within their communities.

The KIDS NOW programs continue to expand and make a positive impact on children and families. The programs include: Healthy Babies Campaign, Folic Acid supplementation, Substance Abuse Counseling and Treatment for Pregnant Women, Universal Newborn Hearing Screening, Immunizations for Underinsured Children, Eye Exams, Oral Health, HANDS Home Visiting Program, Early Childhood Mental Health Program, Healthy Start in Child Care, and First Steps, Kentucky Early Intervention System. In addition they support efforts to improve the quality of child cares across the state, including child care subsidy, training efforts, and the STARS rating scales. Oversight and monitoring is led by the Early Childhood Authority, an appointed body housed in the Department of Education.

/2008/ These programs continue to utilize dollars from the Tobacco Settlement Funds under the oversight of the Early Childhood Authority, located in the Kentucky Department of Education. Dr. Steve Davis, Deputy Commissioner, continues to represent the Department for Public Health on that board. //2008//

Expanded Newborn Metabolic Screening
Kentucky passed legislation to expand the Newborn Screening Program from 4 metabolic and heritable disorders to 29 in March 2005 and the program was in full operation by December 2005, including case management for positive or abnormal screens. In the first few months of expanded screening, 24 cases of metabolic diseases were confirmed based on positive screens. A number of these were fatty acid oxidation disorders such as MCAD for which there was no screening prior to December 2005. Identification of these newborns was not previously possible. Kentucky belongs to the Regional Collaborative Four which is the first of seven regions in the nation to employ tandem mass spectrometry in all its regional member states. KY's lab has exceeded the metrics set for Region IV by Mayo Clinic. Dr. Stephanie Mayfield, Medical Director of the Kentucky State Laboratory, presented a paper on the first three months of performance metrics for expanded screening at the 6th Annual International Society of Newborn Screening to be held in September 2006 in Japan. Kentucky has a case management system that tracks 100% of the newborns screened, cases confirmed, and follow-up case management and treatment In the first

year We identified over 178 true positives. The advisory committee, including both experts and parents, continues to meet quarterly. Quality indicators and interesting cases are reviewed. Information regarding the Newborn Screening Program including Parent Brochures and Fact Sheets on each of the tested diseases, Health Care Provider Fact Sheets and Screening Guide and other available resources including the Commission for Children with Special Health Care Needs, the March of Dimes and the National Newborn Screening and Genetic Resource Center may be accessed at http://chfs.ky.gov/dph/ach/ecd/newbornscreening.htm //2008//

HANDS Home Visiting Program

The HANDS program was developed by Dr. Steve Davis in the Department for Public Health in 1998 in response to high rates of child abuse. It was modeled after the Hawaii program and the national Healthy Families curriculum. The purpose of this program is to provide home visitation to overburdened first-time families to assist them in meeting the challenges of parenting beginning prenatally and continuing during the child's first two years of life. Goals of the program are positive pregnancy outcomes, optimal environments for child health and development, and family self-sufficiency. These are the building blocks to create the enviroment for children to live in healthy, nurturing and safe homes and to reduce the likelihood of child abuse and neglect over the long term. HANDS began in eleven pilot counties in December of 1998 and in the spring of 1999, four additional counties were added. In 2001, an additional thirty-two counties were added bringing the total participating counties to forty-seven. 2002 brought about 54 additional new counties totaling 101 participating counties and in 2003, statewide coverage of all 120 Kentucky counties was achieved.

HANDS uses a comprehensive curriculum based on Growing Great Kids. The program uses both professionals and paraprofessionals, with extensive training for all including ongoing training requirements. Paraprofessionals are supervised by professional staff at regular intervals. HANDS is a strengths-based program. Many topics are covered with these high risk families, including pregnancy, interconception, infant & child health education, safety in the home, decision-making and problem solving skills, goal setting, parent-child interaction, early brain development, parenting skills, and support and community referrals. Establishing caring relationships with the family is key. Families are referred thru a screening tool, then have a comprehensive assessment, and services begin with weekly visits.

Evaluation is by an independent outside evaluator and links HANDS service data with birth certificate data, and compare to a similar population. In evaluations focusing on our teen participants seen during their pregnancy, the participants showed lower rates of prematurity and low birth weight, less very low birth weight, fewer congential anomalies, lower infant mortality. Outcomes appear to be dose dependent; i.e. those participants who had 16 or more visits had half the premature birth rate of the comparison group. Those who started the program in the first trimester had only 1/3 the rate of preterm birth. In addition, evaluations now have demonstrated improved educational status of the mother, improved employment, lower than expected incidence of developmental delay, less ER utilization, and much less substantiated child abuse and neglect than the expected rate.

This program is funded by Tobacco Settlement monies through the KIDS NOW program. Services are limited to first time parents and only until the child is two due to funding limitations. Discussions are underway to potentially expand the program.

Early Childhood Mental Health

The Early Childhood Mental Health (ECMH) Program provides direct services to children identified through childcare as having possible mental health issues. Through this program there is a full time early childhood mental health consultant located in each regional mental health center to provide or refer these services. They also provide consultation to the childcare center and train childcare staff to problem solve classroom behavior problems and build resiliency in children. Another component of this program is to build capacity of mental health professionals working with children birth to five years of age by providing free trainings. This program has been

presented as a "Model that Works" at the Association of Maternal and Child Health Programs national meeting.

The program has worked to develop capacity of MHMR staff who can provide mental health services to young children. An increase in referrals for children from birth to two years of age is expected as a result of the implementation of perinatal depression screening for all families enrolled in the HANDS home visiting program, which will require developing more capacity/ providers all across the state.

Kentucky Folic Acid Partnership
The KY Folic Acid Partnership (KFAP) began in September 1999 and has expanded to 92 members representing 56 agencies/organizations and businesses. The KFAP encourages community activities to educate about the use of folic acid to prevent birth defects and has expanded their role to educate communities about preterm birth prevention. In FY08, there were 511 activities provided that reached 6,242,954 participants. Recent activities include PSA's, newspaper articles, pregnancy workshop classes, and health fairs.

The Title V Program -- Access, Assurance and Policy Development

Traditionally, the Title V program has focused on providing access to maternal and child health services through supporting local health departments and through contracts with universities to deliver services within the community setting and on site for the maternal and child health population. Although this continues to be the focus for the Title V programs, a changing health care environment has opened other opportunities to improve the health of women, infants, children and children with special health care needs. Assurance through partnerships, cooperative agreements and contracts will be discussed throughout the Title V Annual Report and Application.

Local Health Departments continue to be the presence of the Department for Public Health at the local level. As in past years, the majority of Title V funding is allocated directly to local health departments to support their activities benefiting the maternal and child population. Local health departments conduct community needs assessments on a regular basis which guide their programming priorities while the Department for Public Health provides regulatory guidance and standards of care, in addition to training opportunities and other resources.

/2008/ The vast majority of Title V Block Grant funding is allocated to local health departments to support community programs that work toward attaining MCH performance and outcome measures. (See budget for details of Title V services provided in Local Health Departments) In addition to MCH Title V funding, revenue from several major sources including KIDS NOW Early Childhood Initiative, Bioterrorism and KCHIP support local health departments. //2008//

The trend in KY is that the direct community services for maternal and child health is occurring more frequently in traditional medical homes than in years past. Factors influencing this trend include more public financing (such as KCHIP) and more effective healthcare systems utilizing a Primary Care Provider. This is occurring more commonly in the areas of family planning, prenatal and well child preventive services. Some rural counties do lack key health providers such as OB/GYNs and Pediatricians. In these cases, local health departments do provide preventive and direct clinical services, as a safety net to assure services are provided regardless of the ability to pay.

The Kentucky Public Health Practice Reference (PHPR), developed by the Department for Public Health, serves as the guidance for clinically based information to support patient-centered health care provided by local health departments. Additionally, the PHPR provides supportive information to assist the professional in providing services within the community outside the clinic setting. Guidelines included in the PHPR will enhance the public health professional's knowledge and understanding of population-focused practice and reflect current information and recognized

treatment recommendations from appropriate literature and authorities. Additional protocols and guidelines that are desired at the local level must be jointly developed by nurses, advanced practice nurses, physician assistants and their collaborating physicians, as indicated. The entire PHPR and semi-annual updates to the document are available on the DPH website at: http://chfsnet.ky.gov/health/dph/dafm/

All local health departments' clinical and administrative operations are reviewed on a regular basis under the DPH's Quality Assurance Review Process. Areas reviewed include the Breast and Cervical Cancer Program, the Family Planning Program, Child Fatality Review, Pediatric Clinical Services, the Tobacco Program and the Lead Poisoning Prevention Program. Using Kentucky's Public Health Practice Reference as the quality assurance standard, a team of registered nurses visits each local health department to conduct staff interviews and clinical record reviews. Issues for discussion include barriers to access, continuing education needs and data collection quality. Specific to the family planning program, appropriateness of care and adherence to the federal guidelines is ascertained during this review. Following an exit interview with key staff, a written report is prepared by the team and the local health department responds with a quality improvement plan to address identified issues in a timely manner.

/2009/ The MCH Title V Block Grant supports a number of other projects for the MCH effort. These include: Maternal Mortality Review, Fetal and Infant Mortality Review (FIMR), the Mental Health/Mental Retardation Suicide Prevention personnel, the UK College of Public Health, MCH Institute. Additional programs supported will be Regional Neonatal Centers at the universities, Injury Prevention program, Young Parents Program (See National Performance Measure # 8 for a description of this program), the Child Development Evaluation program, Nutrition education, Pedicatric Assessment and Prenatal training. //2009//

Universities are also important partners with the Department for Public Health in the continuum of care for Kentucky's maternal and child populations. Kentucky's two tertiary centers are the University of Kentucky (Lexington) and the University of Louisville. They, as well as Eastern and Western Kentucky Universities, Kentucky State University, Pikeville School of Osteopathic Medicine and others collaborate on many levels including training for health care providers, research and the provision of resources for providers throughout the state. Some examples of trainings offered through University contracts includes Prenatal training at the University of Louisville (U of L), Well Child Preventive Health training at U of L and the University of Kentucky (UK) and Breast and Cervical Cancer Screening training at U of L and UK. Family Planning training is provided through the Emory Regional Training Center, Emory University.

Other Key Partners in Maternal and Child Health

In addition to governmental linkages, the Department for Public Health also collaborates with a number of associations, voluntary organizations and advocacy groups with an interest in maternal and child health issues.

The March of Dimes Birth Defects Foundation is another strong partner. ACHI staff participates on the Greater Kentucky Chapter State-Level Program Service Committee and in the allocation of direct community grants supporting maternal and child health programs at the local level. Additionally, staff work to implement relevant programs and projects; such as preconceptual planning, prenatal lead poisoning prevention and prematurity/low birthweight awareness and prevention. These projects and programs are discussed throughout the document.
Kentucky is currently working with March of Dimes and Johnson & Johnson Pediatric Institute on a major initiative to reduce rates of preterm birth in Kentucky. The initiative is called "Healthy Babies are Worth the Wait".

The Kentucky Pediatric Society, the state AAP chapter, has partnered with us on a number of initiatives and that relationship is growing stronger. Our collaborations include mental health

trainings, child abuse and suicide prevention, oral health, and disaster preparedness. Dr. Shepherd participates on their executive committee and strategic planning.

The Kentucky Chapter of ACOG is also partnering with the Department for Public Health on several initiatives, including "Healthy Babies are Worth the Wait", the MOD prematurity steering committee, and a pilot project on smoking in pregnancy. They have included presentations on these topics at official ACOG meetings and invite Dr. Shepherd to attend all their executive committee meetings.

Other key partners include the Kentucky Perinatal Association, Kentucky Hospital Association, Kentucky Early Childhood Authority, Migrant Health Coalition, Foundation for a Healthy Kentucky, Kentucky Child Now, SAFE KIDS, Kentucky State Coalition of Primary Care, Kentucky Center for School Safety and Kentucky Disabilities Coalition, etc.

The Commission's Role in Assuring the Health and Well-Being of CSHCN

The Commission for Children with Special Health Care Needs has a long history dating back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, the Commission has assumed a leadership role in assuring state and local systems of care for children and youth with special health care needs (cyshcn) and in promoting a broader definition of health for CSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This expanded focus has positioned the Commission to take a leadership role in closing the achievement gap by championing the President's New Freedom Initiative and the No Child Left Behind Act among other state and local agencies, the faith community, and community based organizations on behalf of the Cabinet for Health and Family Services.

As a national leader in developing systems to support the transition of cyshcn to adulthood, KY became the first state to develop a Title V performance measure for transition to adulthood in 1997. The focus of staff has evolved from clinic care to care coordination/case management. The development of personal and family competencies that support successful transition are integral components of care coordination and patients five and older are counseled and assisted in transition to adult health care. Within the past year, the Commission has been primary grant writer for two community-based efforts to secure funding through the Administration for Developmental Disabilities and the Department of Labor for services to children and youth with disabilities and their families through comprehensive one-stop centers. Because schools are often the focal point for children and youth and their families, the Commission has developed a strong and productive relationship with the Division of Exceptional Children Services, KY Department of Education. In doing so, we have taken steps to build an infrastructure at the community level that supports both the child's health and educational needs.

Because of the complexity of their medical needs we sometimes forget that children and youth with special health care needs are first and foremost children and youth. They are subject to the same behavioral health risks as their non-disabled peers. Addressing health promotion and injury prevention among children and youth with disabilities represents a new challenge to the Commission. "Graduate" surveys of youth exiting the Commission and Shriner's Hospital (Lexington) found that youth smoke and drink alcohol at levels of typical youth in KY. The surveys also show that graduates use the emergency room at almost double the rates of typical youth and over 1 in 4 of the visits were due to trauma. Obesity and lack of physical activity among CSHCN are clearly issues that must be addressed through patient education and care coordination and through community and school-based interventions that are done in collaboration with our education and public health partners.

/2008/ The Commission has a long and noteworthy reputation for treating children with specific physical diseases, conditions and disorders in a clinical setting. Many areas of the state depend upon Commission sponsored clinics to access specialty care. However, we understood that this model allowed us to reach a relatively small percentage of the special needs population.

Successfully administering Kentucky's early intervention program for 4 years affirmed our ability to identify and resolve service delivery problems associated with the needs of developmentally delayed children. During this period the Commission also discovered that there was available workforce capacity to provide administrative and technical support services for this population. Finally, a careful, detailed analysis of the declining population in need of clinical care for many of the diseases we traditionally treated forced us to consider other segments of the special needs community in need of services that drew on our expertise if we wanted to remain relevant in addressing the needs of CYSHCN.

Our pilot project providing medical consultative support for medically fragile foster children and their families provided another platform from which to assess the needs of a growing population of at risk children. Having secured the support of members of both the Executive & Legislative branches the CCSHCN began careful yet intense collaboration with the Department for Community Based Services (DCBS) to begin defining scope of service and negotiating with Cabinet leaders to contract with an experienced child welfare consultant.
An attachment is included in this section.

B. Agency Capacity

Assurance for the Health of Kentucky's Women, Infants and Children

Capacity - Policy
The Kentucky Medicaid program has maintained its committment to Kentucky's women and children despite challenging financial times. Eligibility for services for pregnant women and children remains at a high level and dis-enrolling women and children has not been supported as a cost-cutting strategy. The commitment to KCHIP also remains firm.

The use of Master Tobacco Settlement dollars to invest in children has also remained a solid commitment despite difficult financial times. In the 2000 Kentucky Legislative Session, the "KIDS NOW!" program was created from tobacco settlement money supporting children from the prenatal period (folic acid supplementation) to birth (home visitation and newborn hearing screening) through age 5. This program added $50 million to programs centered on children in Kentucky, and in excess of $30 million was allocated specifically for programs dealing with maternal and child health, and that commitment remains. Use of the funds and outcomes of the programs are reviewed quarterly by the Early Childhood Authority, and at least annually by the Tobacco Oversight committee.

Capacity - Kentucky Statutes
State statutes relevant to Title V programs are listed below and may be viewed in their entirety at http://lrc.ky.gov

Maternal Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health and Family Services.

KRS 214.160 Requires syphilis testing for pregnant women.

Perinatal Health

KRS 211.651 -- KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health Improvement. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders.
This regulation is currently being revised to reflect the expanded newborn screening legislation that was passed in the 2005 Kentucky General Assembly.

KRS 304.17A-139 to provide for a $ 25,000 cap on coverage for inherited metabolic diseases on medical formulas and a separate cap of $ 4,000 on low-protein modified foods for each plan year.

KRS 311.6526 to requires guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

HB 108 AN ACT relating to the protection of unborn children.
Create a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability.

Pediatric

KRS 156.501 established a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

KRS 200.650 -- KRS 200.676 Kentucky Early Intervention System/ First Steps.

KRS 211.680 -- Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900 -- KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 213.410 -- Authorizes SIDS services.

KRS 214.034 -- KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

KRS Chapter 95A.200 to establish a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and the loss of life.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 -- KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health

care needs.
KRS 200.550 -- KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the Cabinet for Health and Family Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.

911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 To allow ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

2005 Legislation

SB 2 AN ACT relating to health information. Creates the Kentucky e-Health Network Board to oversee the development, implementation, and operation of a statewide electronic health network.

SB 24 AN ACT related to expanded newborn screening.

SB 56/HB 170 related to drugs. Requires the restriction of the sale and display of drugs containing ephedrine or pseudoephedrine; requires identification and limits the quantity available for purchase.
This legislation was a part of Governor Fletcher initiative as a way to stop or reduce the production, usage and sale of Methamphetamine in Kentucky.

SB 172 An ACT relating to health and nutrition in schools. Requires 30 minutes of physical activity each day in schools or 150 minutes per week; to prohibit, beginning with the 2006-2007 school year, a school from preparing or serving deep-fried foods in the cafeteria during the school day, require each school to publish a school menu that specifies nutritional information: require each school to limit access to no more than one day each week to retail fast foods in the cafeteria. Also created the Get Healthy KY! Board.

HB 267 State Budget Bill includes funding for Smoking Cessation Counseling for Pregnant Women covered by Medicaid.

HB 272 AN ACT relating to revenue and taxation. Changes many provisions of state income tax, corporate tax and cigarette excise tax. For low income families the tax threshold raised to the federal poverty level. Cigarette excise tax rose from 3 to 30 cents. 1 cent of the increased cigarette excise tax is dedicated to cancer research.

HB 304 AN ACT relating to international adoption. Requires Kentucky courts to recognize a final adoption decree from a foreign country.

HB 323 AN ACT relating to the establishment of the Off-Road Motorcycle and ATV Commission.

One member of the Commission is to be the Executive Director of the Brain Injury Association of Kentucky.

HB 353 To allow public and private school students to self-administer asthma medications when the school receives written authorization from the parent and health care provider.

/2007/ 2006 Legislation

HB 3 Adds offenses including child pornography to the definition of sex crimes and strengthens restrictions to keep sex offenders away from children.

HB 45 Kin Care Support Program. Requires the Cabinet to staff an 800 # for grandparents with referral information for programs that might assist them in raising Grandchildren. Establishes an affidavit for the provision of educational and health services for individuals who were not the legal guardian for the child in question. Establishes the Cabinet as lead agency in developing the affidavit, provides for penalties if statements on the affidavits are knowingly untrue, and exempts service providers when they act in good faith under the authority of the affidavit.

HB 57 Cabinet for Health and Family Services to maintain a statewide registry for organ and tissue donation.

HB 68 Permits the donation of wholesome food by retail food establishments; requires the CHFS to amend regulation to provide an action process to guide potential donor organizations.

HB 90 Graduated Driver's Licenses for Teenagers.

HB 94 Exempts manufactured home parks, mobile home parks, or recreational vehicle parks operated on a temporary or seasonal basis by local governments from Department for Public Health sanitation regulations.

HB 111 Allows for social security numbers of persons applying for marriage licenses to be supplied automatically to Department for Community Based Services and stored for possible future use by Child Support personnel.

HB 117 Includes heritable disorder testing as recommended by the American College of Medical Genetics; adds the lead based paint provisions of SB188; adds members to KEIS-ICC; adds ATV helmet provisions for children 16 or over; adds primary seat belt provisions effective 1/1/07.

HB 181 Requires health benefit plans that provide benefits for prescription drugs to include an exceptions policy or an override policy which provides coverage for the refill of a covered drug dispensed prior to the expiration of the insured's supply of the drug; and mandates that insurers provide notice in existing written or electronic communications to pharmacies doing business with the insurer, the pharmacy benefit manager if applicable, and to the insured regarding the exceptions policy or override policy.

HB 283 Increases appropriation for Low Income Home Energy Assistance Program (LIHEAP) by $10 million.

HB 374 Requires a government agency when filing an administrative regulation, to conduct an analysis to explain how a regulation will affect regulated entities; requires that electronic registration be available from a centralized state government Web site developed and maintained by the Commonwealth Office of Technology; mandates a small business ombudsman at each cabinet to respond to small business inquiries concerning administrative regulations and the process for submitting comments; and require a fiscal note relating to any aspect of state or local government with projected cost or cost savings to the state and all its affected agencies as well as local governments.

HB 380 Budget included additional funding for Childhood Lead Poisoning Prevention, the Poison Control Center, continuation of the KCHIP program, Teacher salaries, and Education Technology.

HB 475 The Department of Education, in cooperation with the Department for Public Health, shall develop and make available information about meningococcal meningitis and its vaccine to local school districts in an efficient manner including posting the information on its Web site.

HB 540 Requires that the Department for Public Health develop a hepatitis C awareness and information program and report to the Interim Joint Committee on Health and Welfare by December 6, 2006 and every six months thereafter.

HB 646 Creates the Governor's Wellness and Physical Activity Program, Inc.

SB 19 Directs electronic health information and Kentucky E-Health to include living will, organ donation and advance directive information.

SB 58 Adds CHFS CIO (or his designee) to the Telehealth Board.

SB 61 Ratifies Office of Health Policy reorganization.

SB 65 Controlled substances prescriptive authority for ARNPs.

SB 98 Requires administrative bodies to consider the costs to state or local governments when promulgating administrative regulations.

SB 106 An Act relating to Breastfeeding.

SB 146 Makes several adjustments to the current Supported Living Program.

SB 174 Creates a centralized resource and referral center within the Department for Mental Health and Mental Retardation Services if federal, state, or other funds are available; designs the center as a one-stop, seamless system to provide aging caregivers with information and assistance with choices and planning for long-term supports for individuals with mental retardation and developmental disabilities.

SB 180 Provides statutory authority for CHFS to: 1) Operate the Kentucky Physicians Care Program; 2) Provide a toll-free hotline referral service to assist citizens who do not have health insurance to access volunteer and free healthcare services and resources; 3) Establish enrollment sites at the DCBS for individuals referred; and 4) Create a mechanism for assisting uninsured individuals to receive no-cost healthcare services through the program.

SB 202 Requires the Department for Public Health to establish a multigenerational osteoporosis prevention and education program to promote public awareness of the causes of osteoporosis, options for prevention, the value of early detection, and treatment, and to increase health care provider awareness of national clinical guidelines related to the prevention, diagnosis, and treatment of osteoporosis.

SJR 176 Joint Resolution to submit an application in response to any solicitation from the federal CMS for states to participate in a Medicaid pay-for-performance demonstration to improve the quality of long-term care if CMS provides funding for the administrative and operational costs; explore opportunities to participate in federal pay-for-performance demonstrations that would provide financial incentives to nursing facilities for improvement in the outcomes of care.

HR 324 Encourages the Environmental and Public Protection Cabinet (EPPC) to work with the Cabinet for Health and Family Services to establish a toxic mold program for residential buildings

and schools.

SJR 184 Encourages the Cabinet to establish the Kentucky Youth Development Coordinating Council; establish membership and permit the creation of subcommittees of the council; require the University of Kentucky Cooperative Extension Service to perform the administrative functions of the council; identify the duties of the council; mandate that the council submit a report to the Governor and the General Assembly by September 1 of each year; and require all appropriate executive, judicial, and legislative branch agencies to cooperate with the council.

SR 323 Department for Community Based Services modernization. //2007//

/2008/ 2007 Legislation

Boni Bill - (Named after the Social Worker murdered in 2006.) HB 362 creates a safe work environment for employees and security for workers in the field, and adds 67 new positions to help lesson the work load of overworked Social Workers.

Breastfeeding- SB 111 excuses breastfeeding mothers from jury duty.

Human Trafficking-SB 43 makes transportation of persons for forced labor, sexual exploitation or other illicit activities a felony.

Sex Offenders-SB 65 requires convicted sex offenders to disclose their Internet user names or other online identities.

Minimum Wage-HB 305 raises wage to $5.85 in 2007; $6.65 in 2008; and $7.25 in 2009.

Mine Safety-HB 207 adds new safety requirements for coal mines.

Fire-Safe Cigarettes-HB 278 requires fire safe paper that extinguishes itself if there is no puffing.

Once again the Booster Seat Bill was introduced but failed to pass in the Kentucky Legislature. //2008//

/2009/ 2008 Legislation

HB 91 Bullying Bill: Requires school districts to have plans, policies, and procedures dealing with disruptive and disorderly behavior including harassment, intimidation or bullying.

HB 186 Student Dental Health Certificates: Requires a dental exam the first year that a 3, 4, 5 or 6 year-old child is enrolled in a public school, public preschool or Head Start program beginning with the 2011-2012 school year.

HB 187 Tuberculosis Risk Assessment: Requires applicants for certification as a family child-care provider to produce a copy of the results of a Tb Risk Assessment.

HB 371 Trauma Care: Provides authorization for the creation of a state Trauma Care system. No funding was provided.

SB 120: Booster Seat: Requires a child under age 7 years between 40 and 50 inches in height be secured in a child booster seat.

The Budget Bill included $250,000 for School Based Health Centers. //2009//

Capacity - Division of Maternal & Child Health (formerly Adult and Child Health Improvement)

The Division of Maternal and Child Health is located within the Department for Public Health. Steve Davis, M.D., led the Division for 11 years, then was appointed Deputy Commissioner of the Department for Public Health.

Ruth Ann Shepherd, M.D., F.A.A.P., C.P.H.Q., became Title V Director and the Director of the Division of Adult and Child Health Improvement in September 2005.

The Division of Adult and Child Health Improvement (ACHI) was comprised of five branches; Maternal and Child Health, Chronic Disease Prevention and Control, Nutrition Services, Health Care Access, and Early Childhood Development. In April 2007, a reorganization moved the Chronic Disease and Health Care Access branches to a new divison of Prevention and Quality Improvement. This included Tobacco Control, Diabetes, Arthritis, Osteoporosis, Comprehensive Cancer. Physical Activity, and Obesity prevention; however, there remain close working relationships between these programs and the MCH staff. This change returned the ACHI Division to its original and primary focus on maternal and child health issues, including 3 branches as described below: Maternal and Child Health, Nutrition Services and Early Childhood Development. The Oral Health section was moved to Maternal and Child Health.

/2009/ Effective June 16, 2008, the Division of Adult and Child Health Improvement is officially the Division of Maternal and Child Health. //2009//

Early Childhood Development Branch
The Early Childhood Development (ECD) Branch provides active leadership in achieving the health goals of the state's early childhood initiatives and implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct interventions to children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major birth to age three programs in the state for both children with and without developmental concerns.

The Branch has three sections, Early Childhood Promotion, Early Childhood Intervention and Newborn Screening & Genetic Services. The Early Childhood Promotion Section is comprised of three initiatives that were included in the early childhood legislation, KIDS NOW, that was unanimously passed in 2000 -- HANDS, Healthy Start in Childcare, and Early Childhood Mental Health. In addition, that section administers the ECCS Grant. The Early Childhood Intervention Section includes First Steps, Kentucky's Early Intervention System (Part C) for children birth to age three who have a suspected developmental delay or a medical condition known to cause a developmental delay. The Part C Program was moved to the Department for Public Health in 2004. The NBN Screen &Genetic Services section is home for the Expanded Newborn Metabolic Screening Program, Metabolic Foods and Formula Program, the Kentucky Birth Surveillance Registry, State-wide Genetics and Diagnostic Services. The Kentucky Birth Surveillance Registry provides critical data and information regarding children birth to five with birth defects The Early Childhood Development Branch will also administer the State Systems Development Initiative (SSDI) grant effective June 1, 2006.

Child and Family Health Improvement Branch
This branch was called the Maternal and Child Health Branch before the reorg in June 2008 as it contains many of the traditional MCH programs. It functions with three main sections: Perinatal Health, the Oral Health Section and the Pediatric Section. The Pediatrics Section includes child preventive health screenings (Well Child and EPSDT), School Health, Child Lead Poisoning Prevention, Child Fatality Review and Injury Prevention program, the Coordinated School Health Initiatives, and EPSDT Outreach. The branch assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state.

The Oral Health Section works continuously to make medical professionals as well as non-professionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities including fluoride varnish, dental sealants, surveillance, and mobile dental clinics. The vision is that oral health is integral to general health and most oral diseases are highly preventable using evidence-based approaches. Oral Health initiatives also target pregnant women and the links to preterm birth.

The state dental director has a new partnership with the Kentucky Chapter of the American Academy of Pediatrics to implement a grant from the national AAP. Kentucky members (pediatricians) participate in a pedodontist-moderated webcast regarding oral development, conditions and disease processes with an emphasis on early childhood caries. Dr. McKee followed up with webcast participants with a "Lunch and Learn" event that reviewed the highlights of the webcast and did hands-on training and demonstration/return demonstration on fluoride varnish application on the very young patient. These training opportunities included pediatricians and nursing staff and were held in the pediatric offices throughout the state.

Nutrition Services Branch
The Nutrition Services Branch includes the Nutrition Program, WIC Program, 5 A Day Program, and the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture. The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. The program is also responsible for promoting breastfeeding, resulting in 31% of low-income women breastfeeding.

The Nutrition Services Branch, in collaboration with the Department of Agriculture, administers the WIC Farmers' Market Nutrition Program (FMNP). FMNP provides participants in the WIC Program with coupons to purchase fresh fruits and vegetables at local farmers' markets. Through this program, WIC participants receive the nutritional benefits of fresh fruits and vegetables and nutrition education concerning 5 A Day. Forty-one (41) local agencies/sites, approximately 23,313 WIC participants and approximately 600 farmers received the benefits of this Program.

The Medical Nutrition Therapy program provides medical nutrition therapy to eligible clients in 120 counties and community nutrition education services to all counties. Each local health department must assure the services of a Registered Dietitian for referring clients who need medical nutrition therapy. The Program goals are to; promote healthy eating that follows national guidance policy, impact policy that improves access to healthy foods, and promote healthy weight among adults and children. Besides providing medical nutrition therapy to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff. The community programs use proven strategies such as the 5 A Day Program, Choose 1% or Less Program, weight loss classes, cooking classes, and menus for day care centers and schools.

/2009/ The Kentucky WIC program has been innovative in moving to electronic formats for everything from vendor management to the breastfeeding peer counselors tracking and reporting. The WIC Program applied for and was awarded a $1.5 Million USDA grant to develop and pilot an on-line, integrated EBT system in 2 counties. The Program will design, develop and implement a WIC integrated system for up to 4 corporate retailers as well as other retailers in the pilot counties. The WIC Program also applied for and was awarded a USDA Infrastructure Grant to design a web based Management Evaluation system. //2009//

Capacity: Division of Women's Health

This Division was created in the reorganization to absorb the Office of Women's Health that was housed elsewhere in the cabinet, as well as the DPH women's health programs. This Division focuses on promotion of women's health, as well as clinical services and prevention education. Programs include the Women's Breast and Cervical Cancer program, Title X/Family Planning services including Folic Acid supplementation and counseling and Sexual Violence Prevention and Education program, Adolescent Health, Abstinence and pregnancy prevention and Positive Youth Development programs. The Division is responsible for the Sexual Assault Prevention and Education Grant, but partners with the Dept for Community Based Services for its implementation. Dr. Ruth Ann Shepherd, is the acting Division Director. Joy Hoskins, RN, former lead of the Title X program and Section Supervisor for the Women's Health Section, is the Assistant Director.

/2009/The Kentucky Women's Cancer Screening program has accomplished improvements in the data system that have allowed us to meet all of CDC's 11 data indicators for the program consistently for 6 quarters. The program continues intensive outreach to women who are rarely or never screened.

The Division has taken over the Breast Cancer Trust Fund, a legislated fund for education, outreach, and research for breast cancer. The funds are adquired thru sale of a breast cancer license plate and from a check-off on the Kentucky income tax forms. Proposals are submitted annually and reviewed by an independent panel for funding.

With technical assistance from the HRSA Office of Women's Health, this division is currently developing a proposal to establish an Office of Minority Health in Kentucky.

The Division is also working collaboratively with the Kentucky Commission on Women. The current Director of that office is Eleanor Jordan, a former state representative and previously an ombudsman for the Cabinet for Health and Family Services. She has chosen women's health as her priority topic for advocacy and education.

Effective June 16, 2008, the Division of Women's Physical and Mental Health was shortened to be called the Division of Women's Health. The programs and services remain the same. //2009//

Capacity: Local Health Departments

The coordination and cooperation between DPH and local health departments cannot be overstated. KY has 16 district health departments and 40 independent health departments providing health care services to 120 counties. Local health departments are the primary prevention presence for maternal and child health services in Kentucky. Traditionally, this has meant that most of the Title V Block Grant funds have supported the direct clinical and preventive services in the local health departments. The Public Health Practice Reference (PHPR), developed by DPH, serves as the guidance for clinically based information to support patient-centered health care in the local health departments and compentency training is arranged on TRAIN. DPH Management holds monthly meetings with LHD Administrators.

Capacity: Commission for Children with Special Health Care Needs*

A Memorandum of Agreement between the Commission and the State Division of Disability Services assures that children who apply for SSI benefits receive referral and outreach services.

Families may access Title V/CSHCN services through 14 regional offices across the state. Direct medical services are provided to children with certain conditions, both congenital and acquired. See locations of regional offices and list of conditions treated by the Commission at http://chs.ky.gov/commissionkids/clinics.htm. The Commission provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty

physicians at clinic sites in 26 of the state's 120 counties. Clinics for some complex conditions that require multi-disciplinary treatment teams are held only in Louisville and Lexington due to availability of providers. Families in need receive financial support to assist with travel and/or lodging in order to attend these clinics or receive hospital services.

The Commission maintains a local provider network through contracts with approximately 350 pediatric specialty physicians and 150 dentists throughout the state. Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. The Commission also contracts for foreign and sign-language interpretative services to assure access to care for families of diverse cultures including those with hearing impairments. These services are available in each Commission region. A need for interpretative services is identified during intake and arrangements are made for appropriate service prior to clinic or other Commission appointments.

Previously, the Commission had reported on the transfer of the State's early intervention services program, which is partially funded under the Individuals with Education Act (IDEA) Part C. Effective March 1, 2004 this program was transferred from the Commission to the Department for Public Health. In 2002 in conjunction with the program transfer, the Commission initiated an extensive planning process involving over 70 stakeholders, to study and recommend actions for improving agency capacity to respond to the health and developmental needs of cyshcn. Since then, the Commission has added a developmental transition checklist to the Internet-based case management and reporting system (CUP). Work is now underway to develop a patient and family centered care plan for use by the nurses, social workers and other health care professionals that serve as care coordinators. The care plan will capture child and family outcomes and improve our capacity to measure and monitor the extent to which are delivering comprehensive coordinated care and achieving the other MCHB performance measures.

In 2004 the Commission secured a Family Support 360 Planning Grant from the Administration for Developmental Disabilities to provide services to persons with disabilities in an integrated one-stop setting. Partnering with KY-SPIN, Inc. (KY Special Parent Involvement Network- the state Parent Training Information grantee) and Seven Counties Services, Inc. (the regional mental health/ mental retardation/developmental disabilities agency), the Commission initiated a community planning process in the Louisville Metro to develop a transition and self-determination resource center in the existing network of one-stop health, education, and human services centers known as the Neighborhood Place. As principle investigator on this grant, the Commission has expanded its role from specialty care provider to include community development and integrated systems development. Though the Commission was not awarded the implementation grant we and all the original partners, 7 Counties, KY-SPIN, were committed to pursuing the established goals of developing a transition resource center for individuals with disabilities and their families. These centers will increase opportunities for families to connect with services and supports. An advisory committee has been established and meets monthly. Ultimately, community partners will develop a training packet to educate community members about on going issues faced by the disability community, existing laws designed to protect the disabled, and to help staff communicate more effectively with families. We plan to implement a statewide campaign to educate stakeholders at the state and community levels about the needs of cyshcn using the National Survey of CSHCN and other data. Building upon community partnerships formed during the implementation of universal newborn hearing screening and vision screening for children entering school under the KIDS Now initiative, our goal is to act as a convener and engage our partners to develop a shared vision and plan for achieving a system of care unique to their community.

The Commission is working to continue to expand the capacity of its health information system to fully support the core functions of public health as relates to cyshcn: to assure early identification and screening leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the

collection, analysis, and reporting of data and progress in meeting performance targets. To this end, grant funds from MCHB for State Systems Development Initiative (SSDI) will be used to support the link between the Title V cyshcn database (including UNHS) with vital records and other public health systems maintained by CHFS.

/2009/ Enhancements to CUP have enabled birthing information from hospitals to be electronically transferred into CUP. Over 90% of hospitals have chosen to submit their data electronically. Transcriptionists now have the ability to type dictated medical reports directly into the system thus making reports from health care providers visible immediately to Care Coordinators. An imaging feature has also been added which allows documents to be scanned & uploaded. //2009//

/2008/ Capacity: Special Projects

Data Mini-Grant: The Department for Public Health received an AMCHP CDC Data Mini-grant. A one-day workshop was conducted by faculty from the University of Kentucky, College of Public Health in May 2007. The goal of the workshop was to increase the epidemiology capacity and enhance the skills of staff in accessing and using existing data for planning and evaluating public health interventions and programs.

CDC Epi Assignee: The Department for Public Health has applied and been approved for a CDC Epidemiology Assignee. Dr. Sarojini Kanotra will be the assignee for Kentucky. Dr. Kanotra has had extensive training and experience in maternal and child health, and has served as a guest researcher with CDC as well as an evaluation consultant with the Georgia Department of Health. Her areas of expertise include PRAMS, Perinatal Periods of Risk, and FIMR. Dr. Kanotra previously was the Epidemiologist/Evaluator for the Healthy Start Program in Louisville.
/2009/ Although it was expected that a Centers for Disease Control and Prevention (CDC) Senior MCH Epidemiologist assignee was going to be assigned to Kentucky, this has not occurred to date. There have been barriers in completing the hiring process, and it is unknown at this time if the paperwork issues will be worked out to place this individual in the Division of Maternal and Child Health. Dr. Ruth Ann Shepherd, Division Director of Maternal and Child Health continues to communicate with the potential assignee and the CDC to monitor progress. //2009//

HRSA Graduate Student Intern: A graduate student intern was matched thru HRSA's program to help DPH undertake a PRAMS pilot project in Kentucky. Ayana Anderson completed her MPH at UK and has been working with DPH through the HRSA Graduate Summer Intern Program. Ms Anderson has been the lead in the development of a PRAMS pilot project that KY plans to begin in Fall 2007. The purpose of the PRAMS Pilot is to collect data that focuses on maternal behaviors and attitudes prior to and during pregnancy and birth outcomes, so that we can have better information for developing strategies and health policy.
/2009/ Ms. Anderson began full time with the Kentucky Department for Public Health on March 1, 2008. //2009//

MCH Institute: Kentucky is a state with many maternal and child health problems, but currently no training programs that specifically develop public health expertise in maternal and child health. With the support of Dr. Steve Wyatt, Dean of the UK College of Public Health, DPH has contracted with the University of Kentucky, College of Public Health to develop and administer the MCH Institute to increase Kentucky's capacity to address MCH performance and outcome measures. The initial goal is to set up a certificate program for current public health professionals who are working in or interested in furthering their knowledge of MCH. Dr. Jim Cecil, former DPH Oral Health Director, will be the MCH Institute Director. //2008//

/2009/ Dr. Cecil continues to develop the MCH Institute at the University of Kentucky. An Advisory Committee is working to establish the program. Enrollment for a Graduate certificates in MCH should begin in fall of 2008. Technical assistance and adivce have

been solicited from the University of Alabama-Birmingham School of Public Health and Dr. Russ Kirby, and from HRSA/MCHB Officials, Dr. Peter Van Dyck, Dr. Ann Drum, and Ms. Laura Kavanagh regarding MCHB programs and opportunities.

"Healthy Babies are Worth the Wait": This is a 3 1/2 year prematurity prevention initiative with National March of Dimes and Johnson & Johnson working as a national demonstration project to see if we can take what is already known and apply it to reduce preterm birth at the community level. For details, see Program Activities. The initiative has raised our capacity in a number of ways. This initiative has been promoted on a national level by March of Dimes. Three abstracts on the program were presented at the American Public Health Association meeting in 2007. Dr. Shepherd has presented the project and information on the late preterm in several states, and a grand rounds at the National Center for Health Statistics. A number of national experts on late preterm, patient safety, smoking in pregnancy, and other related topics have been brought to Kentucky through this initiative. Dr. Shepherd has been appointed to the National Quality Forum Steering Committe on Perinatal Indicators due to this visability. This initiative was the only state initiative highlighted at the recent Surgeon General's Conference on Prevention of Preterm Birth. //2009//
An attachment is included in this section.

C. Organizational Structure

Office of the Governor

In 2003, Ernie Fletcher, M.D. was elected Governor of the Commonwealth of Kentucky. Governor Fletcher has a B.S. from the University of Kentucky College of Engineering and later graduated from the University of Kentucky College of Medicine. Governor Fletcher was a family practioner and served in congress prior to his tenure as governor.

/2009/ Kentucky elected a new Governor in November 2007. Steven L. Beshear took the Oath of Office in December 2007. Governor Beshear has a B.S. and a law degree from the University of Kentucky. He has spent his life serving Kentucky in the US Army Reserves, as a State Representative, Attorney General, and Lt. Governor prior to his election. As a state legislator in the 70's, with the assistance of his brother, who is a pediatrician, Mr. Beshear led the legislature to the establishment of Kentucky's system of Regionalized Perinatal Care.

Lt. Governor Daniel Mongiardo is a physician and surgeon serving in his home area of Eastern Kentucky. He received his B.S. from Transylvania University and his medical degree from the University of Kentucky School of Medicine. Prior to his election, Lt. Governor Mongiardo was also a State Senator. //2009//

Cabinet for Health and Family Services -- Provision of Health in Kentucky

Governor Ernie Fletcher reorganized Kentucky state government in Dec. 2003. The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services (CHFS). The Cabinet is divided into four administrative units each lead by an undersecretary. The four units are: Administrative and Fiscal Affairs; Health Services; Human Services; and Children and Family Services.

The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following departments: Public Health, Mental Health and Mental Retardation Services, Medicaid Services, Disability Determination Services, Human Support Services and Community Based Services. It also includes the Commission for Children with Special Health Care Needs, and the following offices: Ombudsman, Certificate of Need, Inspector General, Legal Services, Fiscal

Services, Human Resource Management, Technology, Contract Oversight and Legislative and Public Affairs.

/2008/ The Department of Aging and Independent Living, the Office of Health Policy and the Governor's Office of Wellness and Physical Activity (GOWPA) were created in the Cabinet reorganization in December 2006. The Department for Medicaid Services is no longer under the Undersecretary for Health but reports directly to the Cabinet Secretary. //2008//

Dr. James Holsinger Jr., M.D. was named Secretary of the Cabinet for Health and Family Services by Governor Fletcher. Dr. Holsinger is the former Chancellor of the University of Kentucky Chandler Medical Center.
Upon the retirement of Dr. James Holsinger on December 31, 2005, Mark Birdwhistell was named Secretary of the Cabinet for Health and Family Services. Dr. Holsinger remains on faculty at the University of Kentucky in the College of Public Health. Mr. Birdwhistell was previously the Cabinet Undersecretary for Health Services. Mr. Birdwhistell has been the chief executive officer of CHA Health, a Lexington managed care organization that covered 200,000 members. He previously held positions with the University of Kentucky Hospital and the KY Department for Medicaid Services.

/2009/ With the change in administration, Governor Steve Beshear has appointed Janie Miller as Cabinet Secretary and Steve Nunn as Deputy Secretary of the Cabinet for Health and Family Services (CHFS) in January 2008. Miller brings more than 30 years of experience to the position, including 21 years developing and administering health care programs. Her career also includes more than 15 years of service in the former Cabinet for Human Resources. Prior to her appointment as Secretary, Miller held the position of Deputy Director of Budget Review for the Legislative Research Commission (LRC). In this role, she was responsible for assisting legislators in facilitating the development of budget bills for all three branches of government. Secretary Miller holds an undergraduate degree in Social Work from Eastern Kentucky University.

Former State Representative Steve Nunn brings 16 years of experience on the Kentucky House of Representatives' Health and Welfare Committee, including 10 years as vice chair, to the position of Deputy Secretary of CHFS. He has also served on the House Appropriations and Revenue Committee, as well as the Appropriations and Revenue Budget Review Subcommittee on Human Resources. During his legislative career, Nunn served on numerous legislative subcommittees focusing on the welfare and safety of children and individuals with mentally impairments.

Effective June 16, 2008, the Cabinet for Health and Family Services was reorganized and the Office of the Undersecretaries were abolished. This change removes four vertical reporting structures to allow for improved communication and decision-making in the Cabinet. Other changes were noted under Agency Capacity. A copy of the new Cabinet organization chart is attached. //2009//

Department for Public Health

In November 2004, Dr. William Hacker was appointed Commissioner of the Department for Public Health (DPH). Dr. Hacker had served as acting commissioner for the department since July 2004 upon the retirement of Dr. Rice Leach. Dr. Hacker joined the Department for Public Health as a Physician Consultant in 2001 and served as Branch Manager for the Public Health Preparedness Branch since 2002, where he has headed up the department's disaster preparedness planning efforts. Prior to joining state government, Dr. Hacker's experience included almost 20 years of private medical practice, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. He received both undergraduate and medical degrees from the University of Kentucky.

Effective April 1, 2006, Dr. William Hacker assumed the role of Acting Undersecretary for Health. His focus will be on the oversight and enhancement of the Departments for Public Health and Mental Health and Mental Retardation Services. Dr. Hacker continues to serve as the State Health Officer for the Commonwealth, as well as the Commissioner of the Department for Public Health. Dr. Hacker meets quarterly with the Deans from all the Kentucky-based Colleges of Public Health for sharing information, projects, and ideas.

Dr. Steve Davis, Deputy Commissioner of DPH did his undergraduate studies at Morehead State University receiving a Bachelor of Science degree in Biology. He received his M.D. degree from the University of Kentucky and completed his internship and residency in Pediatrics at the University of Kentucky Chandler Medical Center. Dr. Davis remains Acting Title V Director and Director of the Division of Adult and Child Health Improvement until September 1, 2005. In 2004 Dr. Davis received the Beacon of Promise Award from the Lexington Family Care Center. The Beacon of Promise Award is presented to a public figure that has made an extraordinary contribution to the welfare of children and families.

Ruth Ann Shepherd, M.D., F.A.A.P., C.P.H.Q., became the Director of the Division of Adult and Child Health Improvement September 1, 2005.

The Department for Public Health (DPH) is the only agency in Kentucky responsible for developing and operating all public health programs for the people of the Commonwealth. Kentucky Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease." Dr. Hacker says "The Department for Public Health is about 400 employees assisting 4000 Health Professionals to care for over 4 million Kentuckians and we touch their lives in some way every day."

The Department for Public Health underwent reorganization in April 2007. Two new Divisions were created and some Branches were realigned. The new Division of Women's Health is described under Agency Capacity. Dr. Ruth Ann Shepherd, Title V Director, is the Acting Division Director in addition to Director of the Division of Adult and Child Health Improvement. DPH is divided among seven divisions described below:

Division of Maternal & Child Health, formerly Adult and Child Health Improvement (ACHI) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations.
/2009/When the reorganization became official, in June 2008, the name of this division was changed back to Maternal and Child Health, emphasizing the focus on MCH populations and issues. The Chronic Disease and Health Access sections were moved to the new Division of Prevention and Quality Improvment. //2009//

Division of Women's Health oversees the women's health programs and initiatives in the Department. Their focus is on adolescent, preconcpetion and interconception care, and cancer screening. The Division is described in the Capacity section of this grant.

Division of Epidemiology and Health Policy is responsible for communicable disease prevention (immunization, HIV, TB, STD, etc.) and control, disease surveillance and investigation, adult injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010. This Division is also led by a pediatrician, Dr. Kraig Humbaugh. MCH Programs work closely with this division's programs including emergency preparedness, Immunizations, HIV, Communicable disease, and vital statistics. Vital Statistics has implemented an electronic birth certificate for all birthing hospitals. As the result of collaborative efforts, screens for this data also produce the documentation for newborn metabolic screening and universal newborn hearing

screening. Kentucky is currently working on a system for electronic death certificates.

The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the Kentucky. They identify agents from communicable disease outbreaks, as well as from bioterrorism threats.

The Division of Public Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems.

The Division of Administration and Financial Management develops and oversees the Department for Public Health's budget as well as local health department's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement and contracts, information technology and administrative support to local health departments in all 120 counties of the Commonwealth.

The new division is the Division of Prevention and Quality Improvement assumed responsibility for Chronic Disease Prevention and Control, Health Care Access programs, the Quality Improvement program, department training, and the BRFSS. Dr. Regina Washington is the Division Director. Dr. Washington obtained her BA from Berea College, MA in Health Sciences from Eastern Kentucky University, and a DrPH from the University of Kentucky College of Public Health. She has experience in teaching, rural health program, and cancer screening and prevention.

Division of Maternal and Child Health (Formerly ACHI)

The Division of Maternal and Child Health (MCH) has 3 branches including Nutrition Services, Early Childhood Development and Child & Family Health. These are described in the Capacity section. This division, through the Title V grant and other activities, seeks to provide leadership, in partnership with key stakeholders, to improve the physical, socio-emotional, safety and well-being of the maternal and child health population that includes all of Kentucky's women, infants, children, adolescents and their families. For over 50 years, MCH has provided the foundation for addressing issues related to the overall health of the community. This mission is carried out in collaboration with partner agencies, primarily, local health departments, other state agencies and state universities to increase capacity for clinical and community-based services for the MCH population. At the state level, MCH goals are achieved through policy and program development, special grants, surveillance, consultation, technical assistance, education, training and case management.

Children with Special Health Care Needs

The Commission's executive office, division directors, and statewide administrative staff are located in the central office in Louisville. The 3 Nurse Service Administrators live and maintain offices in the regions they manage. This level of regional, community-based management allows timely supervision and intervention as issues arise; identification of emerging issues that may impact the agency and population served; and reinforcement of program objectives on a consistent, statewide basis.

As previously mentioned, effective 3/1/04 Kentucky's early intervention program was transferred to the Division of Adult and Child Health Improvement. The Medical Director, Dr. J. William Holmes continues to provide medical oversight for the CCSHCN's Title V program. Program divisions include: 1) Health and Development; 2) Administrative Service; and 3) Quality Outcomes Management.* See attached Organization Chart. The division of the Commission's local statewide offices into three distinct regions with Nurse Service Administrators as regional

managers was maintained within the Division of Health and Development.

The Commission's Executive Director, Medical Director, and Directors of the Divisions of Administrative Services, Health and Development and Quality and Outcomes are appointed by the Governor, as are members of the Board of Commissioners, and the Hemophilia Advisory Committee. The Commission's Executive Director with approval of the Board of Commissioners appoints members of the Medical Advisory Committee. The primary role of the Board of Commissioners is to provide oversight and approval of the executive director's actions. The Board meets quarterly with the Executive Director and senior management staff to review program status, consult and advise on programmatic concerns, and take voting action as may be required on certain issues or business such as appointments to the Medical staff.

Under the newly reorganized Cabinet for Health and Family Services, the Commission reports to the Undersecretary for Children and Family Services, Eugene Foster, ED.D. Additionally, he brings a wealth of experience and expertise in strategic planning, staff development, and community capacity building for systems change. Dr. Foster resigned as Undersecretary to work with the Commission as a Child Welfare Consultant.
/2009/ Dr. Foster resigned from the Commission effective 6/30/2007 to the private sector. The CSCHSN now reports directly to the Cabinet Secretary. //2009//
An attachment is included in this section.

D. Other MCH Capacity

Senior Management

Director - Division of Adult and Child Health Improvement
Ruth Ann Shepherd, M.D., F.A.A.P., C.P.H.Q. was appointed Director of the Division of Adult and Child Health Improvement and began her duties on September 1, 2005. She received her B.A. in Biology/Pre-med from Asbury College, in Wilmore, KY, magna cum laude and her M.D. degree from the University of Louisville School of Medicine. Dr. Shepherd did her residency in Pediatrics at Methodist Hospital Graduate Medical Center in Indianapolis, Indiana and her Neonatology Fellowship at Medical University of South Carolina in Charleston, SC. Dr. Shepherd has Board Certifications from the American Board of Pediatrics and the American Board of Neonatal-Perinatal Medicine. Dr. Shepherd professional experience includes partner in private practice in Neonatology and General Pediatrics in Louisville, KY and then became Director of Neonatology Services at Pikeville Methodist Hospital, a Regional Level II+/3A Neonatal Intensive Care Unit with Regional Neonatal Transport Service, Infant Apnea Program, Neonatal Developmental Follow-Up Clinic, and Early Intervention System 0-3 Intensive Evaluation Team, and Medical Advisor to the Infant Hearing Screening Program. Dr. Shepherd is on the Board of the Greater Kentucky Chapter March of Dimes and the Kentucky Perinatal Association.
/2008/ Dr. Shepherd is also currently the Acting Division Director for the Division of Women's Health.
/2009/ Dr. Shepherd has presented on behalf of Kentucky at the American Public Health Association, the National Center for Health Statistics, and the Surgeon General's Conference on Preterm Birth. She is currently serving on the National Quality Forum Steering Committee for Perinatal Indicators. //2009//

Assistant Director, Division of Adult and Child Health Improvement
Marvin Miller, MSW, is the Assistant Director for this Division. Mr. Miller has worked in public health for over thirty years, and has been assistant director in Maternal & Child Health for over 20 years. Mr. Miller has been instrumental in the development of our WIC program, Well Child Program, and others. A few of his accomplishments include the establishment of EPSDT outreach, a child safety seat program, and our HANDS home visiting program. Some of Mr. Miller's current functions include legislative liaison for the Division, and oversight of the local health department's plan and budget process.

Assistant Director, Division of Women's Health
Joy Hoskins, RN, BA, is the Assistant Director for Women's Health. Ms. Hoskins has a BA in Journalism from the University of KY and an ADN from Midway College. Her experience includes Medicaid Services, Childhood Lead Poisoning Prevention, Family Planning and Women's Health section supervisor. Ms. Hoskins has been with the Department for Public Health since 2000. //2008//

Branch Manager, Maternal and Child Health
Leading this branch since September of 2002, Linda Lancaster has been with the DPH since 1988; working with Kentucky's Early Intervention Program (First Steps), Kentucky's Birth Surveillance Registry, State Folic Acid Supplementation Program, Adult Preventive and Arthritis programs. Ms. Lancaster has an Associate Degree in Nursing from the University of Tennessee School of Nursing, a Bachelor of Science Degree in Health Education from Peabody College at Vanderbilt University and a MPA from Kentucky State University School of Public Administration.

Branch Manager, Nutrition Services
Frances M. Hawkins manages the Nutrition Services Branch. Ms. Hawkins coordinates the Nutrition Services Branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Five A Day Program, the Farmers' Market Nutrition Program (FMNP) in collaboration with the Kentucky Department of Agriculture and the Obesity Component of the Centers' for Disease Control Chronic Disease Prevention and Health Promotion Programs Grant. Ms. Hawkins received her training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager, Early Childhood Development Branch
Effective August 1, 2005, Joyce Robl became the Branch Manager of the Early Childhood Development Branch. Ms. Robl brings years of academic and clinical experience in children's issues to this position. Ms. Robl has a BA in Biology from the University of Maryland Baltimore County and a Master's of Science in Human Genetics from the University of Michigan. Board Certified in Genetic Counseling in 1993, Ms. Robl was a member of the University of Kentucky Dept of Pediatric providing genetic counseling services prior to joining the KY Dept for Public Health in 1999 where she has worked in a number of Maternal and Child Health assignments including the KY Birth Surveillance Registry.
/2009/ Joyce Robl returned to the University of Kentucky to complete her Doctoral degree. She continues to lend her expertise to the Early Childhood Branch on a part-time basis.

Jennifer O'Brien was named the Branch Manager of the Early Childhood Branch in October 2007. Ms. O'Brien holds a BA from Emory & Henry College, a MSEd from Virginia Tech University and will complete her DHA in Health Administration from the University of Phoenix in December 2008. Ms. O'Brien has experience as an Infant Intervention Specialist and a Substance Abuse Counselor and has conducted Fetal and Infant Mortality reviews. Prior to her appointment as Early Childhood Branch Manager, Ms. O'Brien was a CDC Public Health Advisor assigned to Kentucky's Immunization program. //2009//

Other Key Program Staff

Title V Administrator
Gwen Cobb is the Title V Administrator and Pediatric Section Supervisor in the MCH Branch. Ms. Cobb earned her BSW from the University of Kentucky and has over 20 years of state government social services and health program experience. Ms. Cobb has worked in the areas of Child Protective Services, Aging Services, HIV/AIDS Prevention and Maternal and Child Health. Ms. Cobb has been with the Department for Public Health since 1999.
/2009/ Ms. Cobb will retire effective July 31, 2008. Her replacement has not been named. //2009//

State Dental Director
Dr. James C. Cecil served as the Administrator of the Office of Oral Health for the Commonwealth of Kentucky. Dr. Cecil received his Doctor of Dental Medicine degree from the University of Kentucky and his Masters in Public Health from the School of Public Health at the University of Michigan. In December 2005, Dr. Cecil was the recipient of the 2005 John W. Knutson Distinguished Services Award at the 133rd American Public Health Association meeting for his lifelong dedication to Dental Public Health. Dr. Cecil was featured in "A Question of Life or Meth," a two-part series aired on the A&E Channel, which received a 2007 Daytime Emmy Award by the National Academy of Television Arts & Sciences. Dr. Cecil retired June 30, 2007 to become the Director of the newly forming Maternal and Child Health Institute at the University of Kentucky College of Public Health. However, he remains active in the MCH effort as the key leader developing the MCH Institute at the UK College of Public Health.

/2009/ Dr. Julie McKee was named the State Dental Director in September 2007. Dr. McKee has a BS in Biology from the University of Kentucky and her DMD from the University of Louisville. Prior to her appointment, Dr. McKee was the Director of the Wedco District Health Department for over 12 years. //2009//

MCH Epidemologist
Tracey D. Jewell is the lead maternal and child epidemiologist for the MCH Branch. Ms. Jewell earned her Master's of Public Health at the University of Alabama Birmingham School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Branch in January of 2001 to assume her present position.
Effective September 1, 2005, Ms. Jewell was promoted to Lead Epidemiologist for the Division of Adult and Child Health Improvement. Ms. Jewell is involved in all ACHI and MCH Epi efforts.

/2008/ CDC MCH Epidemiology Assignee
The Department for Public Health has applied and been approved for a CDC Epidemiology Assignee. Sarojini Kanotra holds a Master's in Public Health from Emory University and Master's and Doctorate degrees in Microbiology from the Indian Agricultural Research Institute in New Delhi, India. Dr. Kanotra is a Certified Health Education Specialist and is a member of numerous professional organizations including the American College of Epidemiology, the American Public Health Association, the Council for State and Territorial Epidemiologists and the Society for Public Health Education. Dr. Kanotra has been a guest researcher at the CDC and an Evaluation Consultant with the Georgia Department of Health. She has extensive experience with PRAMS, PPOR, and FIMR, and has presented her work at the MCH Epi Conference and CityMatch Conference. Dr. Kanotra is currently the Epidemiologist/Evaluator for the Healthy Start Program in Louisville through the Louisville Metro Health Department. Dr. Kanotra's complete Vitae is attached. //2008//

/2009/ Dr. Kanotra has not started her CDC Epi assignment with the KY Dept for Public Health but she continues to be involved in several Public Health projects including FIMR and the state Child Fatality Review. //2009//

/2009/ Ms. Ayana Anderson began as a full time Epidemiologist with the Kentucky Department for Public Health on March 1, 2008. Ms. Anderson completed her MPH at UK and originally began working with DPH through the HRSA Graduate Summer Intern Program from May to August 2007. As a graduate student intern, Ms. Anderson was matched thru HRSA's program to help DPH undertake a PRAMS pilot project in Kentucky. Ms Anderson took the lead in the development and implementation of the PRAMS pilot project that began in Fall 2007. The purpose of the PRAMS Pilot is to collect data that focuses on maternal behaviors and attitudes prior to and during pregnancy and birth outcomes, so that we can have better information for developing strategies and health policy. Ms. Anderson has been analysing the PRAMS data since March 2008 and will oversee a second pilot of the PRAMS program. She will also assist with Title V/Maternal

and Child Health Epidemiology. //2009//

Commission for Children with Special Health Care Needs - Senior Management Staff

Executive Director - Eric Friedlander has been Executive Director of the Commission since June 2000. Mr. Friedlander is a graduate of Antioch College with a B.S. in Economics and has served 16 years in KY state government with experience in administration of health and human service programs. Before coming to Commission, Eric served as manager of Statewide Family Resource and Youth Services Centers Program -- a school based health and human service program designed to remove barriers to children's learning and as manger of the Budget and Policy Branch of the office of Program Support for the Cabinet for Health Services. ***/2009/ Mr. Friedlander was an active member of Gov Breasher's transition team for the Cabinet for Health and Family Services from January to April 2008. Mr. Friedlander retired effective 4/30/2008. //2009//***

Medical Director - J. William Holmes had been medical director at the Commission since November 1993.
/2009/ Dr. Holmes retired effective 1/1/07. Dr. Richard McChane, a board certified pediatrician, assumed responsibilities as Medical Director of CCSHCN (03/07). He has been a faculty member with the University of Louisville School of Medicine, Department of Pediatrics since 1988 and is currently an Associate Professor of Pediatrics, Clinical Services. He has also served as Developmental Pediatrician at the UofL Weisskopf Child Evaluation Center since 07/01/88 and Medical Director of Home of the Innocents since 07/01/01. //2009//

/2008/ Dr. Eugene Foster came to the Commission for Children with Special Health Care Needs to serve as a Child Welfare Consultant. Prior to that he was appointed Undersecretary of Children and Family Services in the Kentucky Cabinet for Health and Family Services. As past Chairman of the Kentucky Children's Alliance Board and previous Kentucky state leader for the Child Welfare League of America, Dr. Foster has been very involved in shaping public policy concerning children and family issues at both the state and national levels. He is a licensed psychologist with a doctorate in school psychology and special education from Boston University. From 2001 until his Cabinet appointment, he was the Executive Vice President of Maryhurst, Inc., a private child welfare agency in Louisville, Kentucky. //2008//
/2009/ Dr. Foster resigned effective 6/30/07 to return to the private sector. //2009//

Director of the Division of Administrative Services- This position remains unfilled. It was previously reported that responsibility for CYSHCN portion of the Title V MCH Block Grant was assigned to Theresa Glore. Ms. Glore retired effective December 31, 2004.

Responsibility for the CYSHCN portion of the Title V MCH Block Grant was assigned to Susan Cole effective April 1, 2005. Ms Cole earned her B.A. from Knox College, Galesburg IL. She was admitted to the Kentucky Society of Certified Public Accountants in August 1995.
/2009/ Ms. Cole will retire effective 7/31/08. //2009//

/2007/ Kevin Mudd, CPA, was appointed to this position in March 2005 after serving over 10 years as Branch Manager of Management Information Systems. Mr. Mudd graduated from the University of Louisville with a B.S. in Business Administration and has served over 20 years in state government. He is responsible for managing all operational components of the Commission including budgets, contract, purchasing, and accounts receivable/payable. Mr. Mudd has also earned several Microsoft IT certification including System Engineer and Database Administrator.
/2009/ Mr. Mudd will retire effective 8/31/2008. //2009//

Director of Health and Development-Rebecca J. Cecil, a graduate of University of Kentucky Pharmacy School was also appointed early in 2005. Ms. Cecil brings 27 years of experience as a healthcare executive to the Commission. She has demonstrated strong leadership skills and is

committed to developing service systems through collaboration and partnership building. //2007// ***/2009/ Ms. Cecil has been appointed Acting Executive Director of CCSHCN. //2009//***

/2007/ Anne L Swinford was appointed as Director of Quality Assurance in March 2005. She received her B.A. Speech and Hearing from Briscia University and a M.S. Speech Pathology from Purdue University. In addition to her experience providing direct care services to the special needs population Ms. Swinford has also functioned as Acting Part C Coordinator and Supervisor of Kentucky's Early Intervention Program. //2007//

Our parent/education liaison, Linda Miller, remains on staff. Ms. Miller is focusing on building partnerships with the state's various family-professional organizations and the Department for Education, Division of Exceptional Children to enhance transition planning and services for cshcn.

/2007/ Ms. Miller's efforts have resulted in the recently established Parent Advisory Council. //2007/

E. State Agency Coordination

Collaboration: MCH / Commission for Children with Special Health Care Needs

The Directors of these two organizations communicate often thru mutual meetings; Dr. Shepherd, as Title V Director, attends CYSHCN board meetings; due to Mr. Friedlander's retirement, communication has not been as frequent in the last few months. The Title V Administrator and the Director of Administrative Services also maintain communication and working relationships. Cooperative ventures between MCH and the Commission include: Newborn Hearing Screening, Folic Acid Supplementation, KY Birth Surveillance Registry, State Systems Development Initiative (SSDI grant), fluoride varnish and screening.

Collaboration - Local Health Departments

Kentucky has a statewide network of 56 local and district health departments with clinics in 120 counties, that serve as the Department for Public Health (DPH) "service arms". Each local health department are quasi-governmental agencies and each operates under the Kentucky Public Health Practice Reference (PHPR) standards of care for the delivery of all clinical services. All encounter service data for the 120 local health departments is captured through a single data system. This allows for complete review and analysis of services rendered in the local health departments.

DPH has developed the capacity to connect to a tele-health network across the state, through satellite webcasts and videoconferencing. The network includes hospitals and local health departments and is used for training, state-wide educational meetings for public health nurses and other programs.

Collaboration: Department for Medicaid Services

The Division of Adult and Child Health Improvement, as the state Title V agent, has a long history of working cooperatively with the Dept for Medicaid Services. Kentucky's CHIP program (KCHIP) is also coordinated through this department as is KenPAC, Kentucky's Managed Care Program. This relationship continues through several Interagency Agreements (Memorandum of Agreement) that are renewed annually and are listed below:

Preventive health services delivered to Medicaid recipients by local health departments and reimbursed by the Dept for Medicaid Services. ***/2009/ Flouride Varnish reimbursement was recently approved to be included in the Preventive Health package. //2009//***

Medicaid reimbursement for early intervention services for infants and toddlers who are

determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with Disabilities Education Act.

Medicaid coverage for home visiting services to pregnant women, parents and children served by HANDS, the Health Access Nurturing and Development Services Program.

Medicaid Services Presumptive Eligibility Program for Pregnant Women is in place and will allow pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.

In general, children and pregnant women in Kentucky are well supported through the KCHIP and Medicaid insurance systems. The service gap identified is for the adult males and non-pregnant females as well as for undocumented immigrants of all ages. And it is the latter group whose increasing numbers stretch the safety net system. Many local health departments are using Title V funding to provide prenatal services to this population.

KenPac - Implemented in 1985, the Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), [formerly Aid to Families with Dependent Children (AFDC)] and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program. In 2001, the KenPAC program added a care coordination support function. The program is staffed entirely by experienced registered nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers. Additionally, on a case-by-case basis, these nurses are available to assist with heath care service coordination for KenPAC recipients with unique health problems.

KCHIP: Eligibility is determined by the Dept for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid. KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

/2007/ The Fletcher administration has focused on modernizing the Medicaid program. Currently, the Kentucky Medicaid program covers more than 691,000 enrollees with an annual budget of $4.7 billion. Kentucky got the first Medicaid Waiver approved after the Federal Deficit Reduction Act. It will allow for pilot projects and more customized plans. including benefit management and technology through contracts for a Pharmacy Benefits Administrator (PBA) and a new Medicaid Management Information System (MMIS). Kentucky Health Choices will focus on improving the care for high-risk, high-cost patients, including long-term care and behavioral health patients, as well as individuals with special health care needs, through case and disease management. The program will also operate a 24/7 member services 800 number that will include access to a "nurse triage" medical advice call service to help members understand their illness and access appropriate levels of care. Kentucky Health Choices will also coordinate a new provider credentialing process consistent with private sector practices, and peer review organization functions.Kentucky Health Choices' aim is to reduce costs and improve health outcomes by promoting healthy lifestyles, managing the care of high-utilizing patients and minimizing inappropriate care. //2007//

/2008/ Medicaid has recently announced a rate increase for physicians and dentists for the top

utilized CPT codes. The increases will amount to $44M but hope to encourage more providers to participate and enhance preventative services, including after-hours care. The state has increased payment rates to dentists for children covered by Medicaid. By increasing payments by almost one-third, officials said, more dentists are expected to agree to treat medicaid children and pregnant women. Less than half of Kentucky's 2,265 licensed dentists accepted Medicaid prior to the rate increase. //2008//

An agreement is in place between the Dept for Public Health, Dept for Medicaid Services and Dept for Community Based Services. This agreement provides Medicaid reimbursement for targeted case management for Medicaid patients (including children in custody or at risk of being in state custody and adults in need of protective services) and for rehabilitative services for Medicaid-eligible children in custody or at risk of being in state custody.

The Dept for Public Health, Dept for Medicaid Services, Dept for Community Based Services and Dept for Mental Health/Mental Retardation Services also have an interagency agreement for provision of community-based mental health services to children who are in custody or under supervision of the state, or at risk of being in state custody; and have just been discharged from a psychiatric facility or at risk of institutionalization in a psychiatric facility.

Collaboration: Department for Mental Health and Mental Retardation (MHMR)

/2009/ In the Reorganization, effective June 16, 2008, The Department for Mental Health and Mental Retardation Services revised its name to the Department for Mental Health, Developmental Disabilities and Addiction Services. The new name reflects the focus of the programs and services provided by the department. //2009//

As part of the KIDS NOW Early Childhood Development Initiative, the Kentucky Division of Mental Health and Substance Abuse is working in partnership with the Dept for Public Health in a statewide effort aimed at increasing the health of all Kentucky babies by decreasing the use of alcohol, tobacco, and other drugs during pregnancy. Health departments screen pregnant women for alcohol, tobacco, and other drugs and women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment to the Comp Care system. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in Kentucky are being reached. The Comp Care Centers working under the KIDS NOW Early Childhood Development Initiative provide substance abuse prevention and /or treatment services to pregnant women.

The Early Childhood Mental Health (ECMH) Program provides direct services to children identified through childcare as having possible mental health issues. Through this program there is a full time early childhood mental health consultant located in each regional mental health center to provide or refer these services. They also provide consultation to the childcare center and train childcare staff to problem solve classroom behavior problems and build resiliency in children. Another component of this program is to build capacity of mental health professionals working with children birth to five years of age by providing free trainings. This program has been presented as a "Model that Works" at the Association of Maternal and Child Health Programs (AMCHP) national meeting in 2006.

Additionally, a collaborative agreement is in place between these agencies to provide mental health services for childbirth to five with regional consultants both for consultation and direct intervention primarily in the child care setting (Healthy Start in Childcare) and the Early Childhood Mental Health Program.

The MCH Branch has a collaborative agreement in place for Suicide Prevention Services and MCH staff serve on the Suicide Prevention Advisory Group. MHMR staff also serve as a member of the State Child Fatality Review Team.

The Substance Abuse Prevention team in MHMR, as part of the KIDS NOW Early Childhood Development Initiative, has been working with many of the MCH programs including the Prenatal program, Family Planning, Well Child and the Kentucky Birth Surveillance Registry. This collaboration is a statewide effort aimed at increasing the health of all babies by decreasing the use of alcohol, tobacco and other drugs during pregnancy. The program components will include outreach efforts aimed at better identifying pregnant and postpartum women in need of prevention or treatment, and collaborative efforts between substance abuse prevention and treatment services to provide a continuum of care.

In October 2004, Kentucky was awarded $11.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The Strategic Prevention Framework is a process designed to increase the effectiveness of substance abuse prevention on the state and local level through collaborative interagency planning.

Collaboration: Kentucky Department of Education

KIDS NOW is the state's early childhood initiative passed by the legislature and is funded by 25% of the Phase I Master Tobacco Settlement dollars. The Early Childhood Development Authority Board, appointed by the Governor, guides the programs and ensures accountability. The Board includes parents and representatives from multiple departments and agencies including Public Health and the Commission for Children with Special Health Care Needs. Dr. Steve Davis, Deputy Commissioner of the Dept for Public Health and former Title V Director was one of the key architects of KIDS NOW and continues to be active on the Board.

The KIDS NOW Initiative is housed in the Department of Education, but works across department lines with Public Health, Education, the Commission for Children with Special Health Care Needs, Child Care, and Mental Health. The goal of the initiative and all partners is that "all children in Kentucky are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthened within their communities." There is a strong evaluation component of the entire initiative and programs regularly report their progress to the board.

/2008/ The First Steps program has a Memorandum of Understanding with the Kentucky Dept of Education to facilitate transition from Part C (birth to three years) to Part B (three to twenty-one years). A full time staff works in communities to develop community-specific agreements for assuring transition steps and services for this population. First Steps also provides electronic notification to the school system to provide Child Find information to every school district for children in the First Steps system who are 30 months or older. This information is provided on a quarterly basis and includes basic contact information regarding the child and family. //2008//

Coordinated School Health: In 2003, Kentucky was selected as one of eighteen states to receive Centers for Disease Prevention and Control - Division of Adolescent School Health (CDC-DASH) Coordinated School Health (CSH) Infrastructure grant. The Kentucky Dept of Education (KDE) and the Kentucky Dept for Public Health (KDPH) partner together to develop, implement and evaluate a coordinated school health program at the state level. The grant award is for $415,000 with $100,000 allocated to the Dept for Public Health to fund a full-time coordinator, travel and supplies. Additionally, 3 FTE positions have been established within the Dept for Education to support coordinated school health activities.

/2009/ Kentucky was one of twenty-two states and one Territory to receive a new five year Coordinated School Health grant award from the Centers for Disease Prevention and Control - Division of Adolescent School Health (CDC-DASH). This will allow a continuation of the infrastructure building and program development to promote the health of our youth so that our children become healthy, productive citizens. School Health issues was the focus of the Kentucky School Leader in Winter 2007-08. This magazine is a publication of

the Kentucky Association of School Administrators. //2009//

Through this state infrastructure, schools and school districts, with assistance from local health departments and other partners, will create and/or strengthen local CSH Programs. CSH consists of an eight-component national model include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Substance Abuse Prevention, Asthma, HIV/AIDS, Well-Child, Abstinence Education, Family Planning, Diabetes, Nutrition, Obesity, Cardiovascular Health and Physical Activity.

/2008/ This group has developed a school-based resource guide book on physical activity, nutrition, tobacco and asthma (PANTA). The handbook was developed by the Kentucky Dept for Public Health and the Kentucky Dept of Education to provide assistance to schools in designing and planning policies and programs, encouraging environmental change, and promoting overall health of students, staff and the school community. This resource helps schools make the changes required by SB 172, our school nutrition bill. Resources are provided that encourage needs assessment [CDC's School Health Index], evidenced-based curriculum, best practices, model policies and answers to frequently asked questions. This guide is arranged in such a manner that it can be used as a whole document or by subject -- physical activity, nutrition, tobacco and asthma (PANTA).

Barren River Area School Health Collaboration

Local and state partnerships amongst the Barren River District Health Dept (BRDHD), local school districts, KY Dept for Public Health, Coordinated School Health (DPH-CSH)and KY Dept of Education, Coordinated School Health (KDE-CSH) have been very forward thinking and active with their vision to work in a cooperative approach to school health. This has resulted in many accomplishments that include:

Two School Health Summits were held in August 2006 and March 2007 that targeted the key decision makers in the school system such as the Superintendent and Principals to engage school and health leaders in dialogue on school health issues. Positive outcomes of the summits include Superintendents initiating conversations about services that they can partner together, a renewed sense of health and education as partners in learning for life, provision of training of trainer and the tools necessary to empower school personnel to implement programs that the health department once provided.

Glasgow and Bowling Green Independent School Districts each received a Coordinated School Health Award recognizing their dedication and involvement of a coordinated approach to school health at the Coordinated School Health Institute in June 2007.

Professional development events such as Coordinated School Health Training for the BRDHD staffs and Coordinated School Health Institutes.

BRDHD received the KDPH "Innovation in Service Delivery" Award for their Center of Excellence in School Health in March 2007. //2008//

Another key partner, Foundation for a Healthy Kentucky (http://www.healthyky.org/), has supported coordinated school-based projects through funding of school grants to expand, replicate or enhance Coordinated School Health Programs in Kentucky communities. Approximately $800,000 for school grants and evaluation were allocated.

Collaboration - Kentucky Youth Development Coordinating Council

/2007/ The Commissioner for the Dept for Public Health is one of 20 designated members of the Kentucky Youth Development Coordinating Council which is given the duty of developing a strategic plan and common vision for KY's Youth serving agencies. //2007//

/2008/ The KY Youth Development Coordinating Council, established as a result of the 2006 legislation (SJR 184) supports adolescent health agencies and their efforts to promote positive youth development outcomes. The Commissioner of DPH is a participating member of the Council. Since the passage of SJR 184, the Council has met on a regular basis and is currently meeting every other month. At these meetings the Council has made decisions that will lay the foundation for success and set the stage for significant progress over the next year. A first year goal is to conduct an inclusive process to develop a strategic plan for coordinating and improving youth services over the next three to five years. Milestones include the following: Council agreed to meeting procedures and to meet six times a year instead of the minimum four suggested in the legislation; the Council decided to appoint two of the three young people who are the youth representatives on the Council as Co-chairs; the Council decided to develop a three year strategic plan; the Council decided to assess current Youth Services Collaborative activities to connect and build on them; and the Council decided to enlist agency program resource people into the visioning and strategic planning process. Moreover, the Council formed four workgroups that will be composed of Council members and resource people: 1) Outcomes/Accountability; 2) Coordination; 3) Quality/Positive Youth Development; and 4) Opportunities to engage youth, families and communities. //2008//
/2009/ The Counci; has identified five outcomes it will work toward. They are: Youth Making Healthy Choices; Youth are Life Long Learners; Youth participate in Community Decision Making; Youth Develop socaila and emotional Competencies, Youth have know and skills to be productive in the 21st century. The Council held a retreat in June 2008 and engaged a national expert from the Forum for Youth Development to establish performance indicators for the above five measures. //2009//

Collaboration: Tertiary Centers

The Division of Adult and Child Health Improvement has contracts with both the University of Louisville and the University of Kentucky for tertiary activities in the areas of genetic services, neonatal care, metabolic services, sickle cell and developmental services. The tertiary centers also provide invaluable consultation and educational offerings to ACHI and hundreds of providers across the state.

-University of Louisville

Community Development Evaluation Services: Community Development Evaluation Services are provided to the Western half of Kentucky through the U of L Child Evaluation Center. They provide 325 multi-disciplinary tertiary evaluations and 260 single-discipline evaluations to children birth to sixteen to determine complex developmental disorders, program eligibility and service recommendations as well as support and educational services to families and health providers. Evaluations are done both at the University's Child Evaluation Center and through a series of traveling clinics across the western half of the state.

High Risk Infant Follow-up Project: The Neonatal Follow-Up Clinic provides developmental screening assessments for high-risk and premature infants for the Western half of Kentucky. The staff provides center based multi-disciplinary neuro-developmental screening to interpret diagnoses to families; identify intervention needs, and initiate specialty referrals. These evaluations are done at both the University's Neonatal Clinic in Louisville and at regional neuro-developmental screening clinics housed in western Kentucky hospitals. In addition, the staff provides technical assistance and education to Pediatricians and other health care professionals on how to manage the needs of the premature, high-risk infant they are serving in their local communities.

Other Contracts Impacting Maternal and Child Health include metabolic screening and case management for children with identified conditions; genetics referral and outreach, maternal mortality, nutrition education for providers of high-risk women; physician and public health nurse continuing education and oral health survey implementation and data analysis.

/2008/ The University of Louisville, College of Medicine will assist DPH to develop and administer a statewide Fetal and Infant Mortality Review (FIMR). //2008//

-University of Kentucky

KY Injury Prevention Research Center works with the DPH Child Fatality Review and Injury Prevention program to facilitate, develop policy, gather and analyze data to identify trends, patterns and risks, provide technical assistance and training, and to review, make proposals and implement strategies to improve the child fatality review and injury prevention system, with an emphasis on coordinating partnership prevention efforts. The Injury Prevention center also cooperates with CDC on the Violent Death Reporting System and the SUIDI project.

Infant Intensive Care Project: The Infant Care Project provides multi-disciplinary developmental assessments to acutely ill children to interpret findings to families; identify intervention needs and to initiate specialty referrals. These services are provided to children admitted to the NICU.

The DPH also has an active collaboration with the state-wide network of county extension agents through the UK Cooperative Extension Agency. Community topics include nutrition, physical activity, smoking cessation and general health promotion.

/2008/ The University of Kentucky will develop and administer a MCH Institute in the College of Public Health. //2008//

Collaboration - CYSHCN and Partners

The Commission coordinates a MOA with the Dept for Medicaid Services that enables the Commission to provide therapeutic remedial services for applicable Medicaid eligible children enrolled for Title V/CSHCN services This agreement references the applicable federal and state statutes or regulations and assure that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89.
Besides key partnerships with ACHI and Medicaid, the Commission for Children with Special Health Care Needs has historically maintained and built new partnerships to enhance the system of care for CYSHCN. In the past year the Commission has worked with the Cabinet for Families and Children to identify Title V/CSHCN enrollees who are residing in foster care and to share program information that will assure coordination of services for children in foster care.

The Commission maintains a strong relationship with the KY Dept of Education, with the Executive Director serving on the State Advisory Panel for Exceptional Students. A MOA between CCSHCN and KDE calls for exploring avenues to link transition related data sets to measure and monitor student progress. The state agency for protection & advocacy, developmental disabilities council, and the university center for excellence in addition to the departments for community based services, vocational rehabilitation, and employment services are partnering with the Commission in the Family Support 360 Planning Grant. The Commission serves on the Dept for Mental Health's Co-Occurring Disorders Workgroup, which is studying the need for appropriate behavioral supports for the growing number of CYSHCN presenting with dual diagnosis. A representative of the Commission serves on the state early intervention Interagency Coordinating Council. The Commission also partners extensively with the two state medical schools and their teaching hospitals for specialty care for CYSHCN enrolled in the Title V medical services

program.

F. Health Systems Capacity Indicators

Introduction

The Department for Public Health, Division of Maternal and Child Health is responsible for promoting normal growth and development and safeguarding the health of Kentuckians of all ages, with emphasis on pregnant women, infants, and children. Its activities include public health education, nutrition, injury prevention, coordinated school health, perinatal care, early childhood intervention and promotion, well child care, oral health and selected primary and preventative care activities. Its activities span the spectrum of population based and personal preventive health services delivered through a wide range of health care providers and related groups to promote good physical and oral health for all age groups.

The state MCH programs work closely with Medicaid and other agencies to develop strategies to enhance Health Systems Capacity as measured on these indicators. Kentucky Medicaid has been very supportive of providing care for MCH populations. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician. One year ago, Medicaid announced a $44 million package to increase provider reimbursement for the most common CPT codes, which will encourage more pediatricians and obstetricians to participate. The package also provides incentives like enhanced reimbursement for after hour visits in the office/ medical home. In addition, the package has shifted some of the dental reimbursement from adult care to enhance the reimbursement for dental services to children. Very few dentists in the state are willing to see Medicaid children, so we are hoping this increased reimbursement rate will improve that access as well.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	68.8	60.6	56.2	47.8	45.8
Numerator	1834	1652	1541	1315	1276
Denominator	266635	272789	274199	274947	278330
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Data includes a primary, secondary or tertiary diagnosis code of 493.0-493.9.

An attachment is included in this section.

Narrative:

PANTA School Resource Guide -- Recognizing Kentucky has a large number of children with asthma; asthma was added to a resource guide for schools. The guide was developed through a collaborative effort of DPH Tobacco, Obesity-Prevention, and Coordinated School health programs, along with the Kentucky Department of Education.
The guide provides assessment tools, evidence-based interventions, and sample policies for Physical Activity, Nutrition, Tobacco, and Asthma [PANTA]. The guide may be downloaded at

http://chfs.ky.gov/dph/ach/cd/pantaguide.htm

School-Based Health
Local Health Departments provide a large number of school-based health services - it is one of the largest volume services for health departments overall. In addition, 16 sites have school-based health centers staffed by a health care provider (pediatrician and/or ARNP). These centers are supported by local funding. One center in Lexington has instituted asthma screenings by the pediatric pulmonologist from UK. In the last legislative budget, additional monies were earmarked to expand school based health services. This was accomplished by funding local health departments to partner with school based health centers to enhance services.

/2009/ DPH is partnering with the Kentucky Department of Education, the Kentucky School Boards Association, and the Kentucky Association of School Administrators to develop a statewide asthma management plan for Kentucky schools. The plan would include collecting data and providing information to key partners and stakeholders; educating school administrators, faculty, staff, and students on appropriate asthma management and emergency response; and communicating among schools, students with asthma, their parents and their physicians.

Kentucky has designated approximately $150,000 of Preventive Health and Health Services Block Grant funds for a full-time asthma program manager and money to begin building an asthma program at DPH. This would include providing resources and information to local health departments that are interested in using discretionary funds to begin developing asthma programs, coalitions, and partnerships at the local level.

DPH has initiated an Asthma pilot program in Montgomery County that includes education, collaboration with local physicians, partnering with school nurses on asthma management and building of a community coalition. The Montgomery County Asthma Pilot Program also works to educate the Spanish speaking community.

DPH also works with the American Lung Association of Kentucky to promote their Asthma Educator Institute to local health department employees who are interested in becoming Certified Asthma Educators. //2009//

Medicaid Pediatric Asthma Initiative
The Department of Medicaid Services (DMS), Division of Medical Management and Quality Assurance (MMQA) implemented this disease management initiative for pediatric asthma to provide the following goals:
• To improve quality of life for children with asthma.
• To educate the parent and child to be better prepared to manage asthma.
• To prevent acute exacerbations of asthma episodes.
• Promote appropriate use of healthcare resources.
• Decrease school absences.
• Improve self-management of asthma.

This initiative has targeted the age ranges of five (5) to seventeen (17) years of age. The counties selected to participate in the pilot include Perry, Pike and Powell. These counties are all located in Eastern Kentucky.

An introduction letter was previously forwarded to providers and members and DMS continues to encourage healthcare providers for their input and assistance with this initiative. DMS MMQA continues to partner with providers, including the Department for Public Health, local health departments and community resources to improve the lives of Kentuckians affected by asthma. Members in the pilot areas are enrolled automatically but are allowed to "opt out."

DMS has adopted specific guidelines from the National Heart, Lung, and Blood Institute (NHLBI).

A chart abstraction was performed that included demographics, history, medications, utilization of services and education. Members and providers are encouraged to fill out an Asthma Action Plan for each child. This is followed by educational mailings and follow-up data is collected by survey and Medicaid utilization data. A member 1-888# and staff are available for comments, to assist members and health providers and to answer questions as needed.

The program was a success upon completion of the one year benchmark review of the member chart abstractions. The members received valuable information in quarterly newsletters to better maintain their child's symptoms. The Pediatric Asthma Initiative in the pilot counties will continue with quarterly mailings to the members and will continue to enroll new members.

Kentucky Pediatric Society (KY AAP) has members who are piloting model programs for asthma management in their offices.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	73.8	78.6	77.0	78.8	78.8
Numerator	16492	16677	16624	17626	17626
Denominator	22361	21230	21580	22354	22354
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Data for this indicator is derived from the CMS annual 416 EPSDT participation report for year 2006.

Notes - 2005
For previous years data, DMS conducted ad-hoc reporting to generate the numbers in the past and, while the numbers reported may be accurate based on the criteria that was used to generate the report at that specific time, the criteria may not have been consistent from year-to-year which would have resulted in the discrepancies. The updated numbers came from the annual HCFA 416 report - a standard report that uses the same criteria each time it is generated. This standard form will be the source of data for this indicator in the future.

Narrative:
The Kentucky Department for Public Health is working with the Department of Medicaid Services to increase screenings with EPSDT outreach. The Department for Public Health allocates money to all local health departments for EPSDT outreach. The health departments work a list of eligibile children which is provided by Medicaid. This program has created a full time position within the Maternal and Child Health branch, which will allow us to work more closely with local health departments to develop and/or expand their EPSDT outreach program.

The Department for Medicaid services administers statewide EPSDT and KCHIP Outreach through contracts established with the Department for Public Health. During FY 08, the Department for Public Health reinforced EPSDT Outreach through development of outreach

goals and objectives, workshops and training for health department providers, and improvement of reports and feedback used by health departments for implementation of verbal notification of eligible Medicaid children. To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

Medicaid is also encouraging EPSDT screenings to include Lead poisoning. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician and is working on strategies to get more pediatricians involved and more consistent with EPSDT.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	83.8	77.9	81.0	84.1	79.9
Numerator	228	342	372	371	528
Denominator	272	439	459	441	661
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Medicaid has been collaborating with the Department for Public Health to encourage EPSDT screening. Outreach thru the local health departments includes outreach to children eligible for KCHIP.

The Department for Medicaid services administers statewide EPSDT and KCHIP Outreach through contracts established with the Department for Public Health. During FY 08, the Department for Public Health reinforced EPSDT Outreach through development of outreach goals and objectives, workshops and training for health department providers, and improvement of reports and feedback used by health departments for implementation of verbal notification of eligible Medicaid children. To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	81.1	75.6	70.5	75.4	74.5
Numerator	44704	42141	37800	42150	42066
Denominator	55147	55775	53647	55893	56497
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 data is preliminary.

Narrative:
Kentucky's women are receiving adequate prenatal care as based on calculations using the Kotelchuck index. In 2000, 80.6% of women of childbearing age in Kentucky received adequate prenatal care and in 2001, this number rose slightly to 80.8%. Data for this measure continues to increase steadily with 82% of women receiving adequate prenatal care, based upon the Kotelchuck Index in 2003.

Following the Kentucky's switch to the new birth certificate in 2004, this indicator was calculated differently than in the past and therefore numbers are not comparable. Like other states who switched, we struggled with how to best calculate this indicator based on the new data source. We have participated in the discussions of this with our Region IV states, and recently received the formula developed by Dr. Bill Sappenfield and now distributed by NCHS. This data is recalculated by the new formula and may be a more accurate representation of this issue. We are currently examining our data by risk factors and geography to develop strategies to address.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	90.7	85.4	89.2	97.8	91.5
Numerator	390982	356053	361554	470710	436253
Denominator	430870	416878	405239	481324	477020
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Medicaid claims can be paid for up to one full year from the date of service so the data is not complete and still considered to be preliminary.

Narrative:
Kentucky Medicaid covers nearly half of all births in the Commonwealth per year and provides health coverage to one out of every three children.

The Medicaid waiver, the first approved after the Deficit Reduction Act of 2005, will eliminate the one-size fits all approach to Medicaid, improve the health status of Kentuckians enrolled in the program and ensure that people receive the right care, in the right setting, at the right time.

The Medicaid Waiver will consist of 4 plans and placement will be determined by level of care:

1. Global Choices will cover the general Medicaid population program including foster children and medically fragile children.

2. Family Choices will cover most children including the SCHIP children.

3. Optimum Choices covers individuals with mental retardation and developmental disabilities in need of long term care.

4. Comprehensive Choices covers individuals who are elderly and in need of a nursing facility level of care and also individuals with acquired brain injuries.

Members will be encouraged to participate in prevention and disease management programs. Disease management programs will be developed throughout the state to assist those with chronic illnesses such as pulmonary disease, cardiovascular disease, pediatric obesity, asthma and diabetes. Get Healthy Benefits will be established to provide incentives to Medicaid members for healthy behaviors.

Children less than 19 years of age will have no MD or preventive office visit co-pays.

Co-pays for children will be on ER Visits and RX only w/ limits of 4 RX @ month and 8 ER visits @ year

Maximum out of pocket per individual per service is $225.

Effective date was May 1, 2006.

The name for the EPSDT Program would be changed to the Children's Health Preventive Program.

It is anticipated that the new Medicaid waiver will not limit services to children.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	45.8	35.1	35.1	49.4	50.6
Numerator	30702	31127	31127	35206	38417
Denominator	67090	88766	88766	71302	75954

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
The number of dental providers accepting Medicaid is declining through out the state and possibly explains the decline.

Narrative:
The Kentucky Oral Health Program continues to work to improve the access for care for children with Medicaid and KCHIP in the following ways:

• The Kentucky General Assembly increased Medicaid reimbursement rates for dental services to Kentucky children by approximately 30 per cent.
• The Kentucky Dental Association continued to be proactive in their promotion of Kentucky dentists serving children eligible for Medicaid and KCHIP.
• Strong partnerships have been developed between the Kentucky Oral Health Program, local health departments and dentists, to promote dental care for Medicaid and KCHIP eligible children, particularly the very young patient, ages 1-5 years.
• Kids Smiles Fluoride Varnish trainings were provided at 23 regional training sites to approximately 1400 health department nurses and other providers since 2003. Oral Health Staff provided 45,145 pre-packed fluoride varnish kits to participating local health departments and Commission for Children with Special Health Care Needs offices.
• In FY 06, a total of 33,832 services (including oral health screenings and fluoride varnish applications) were provided to children by local health departments and Commission clinics.
• The Kentucky Children's Oral Health Surveillance System continued with pilot screenings held at selected Kentucky schools, which enabled project planners to calibrate data collection methods in preparation for the beginning of on-going surveillance activities in fall of 2006. DPH and UK are coordinating efforts to continue surveillance in 09
• Kentucky's sealant program funded sealant activities in local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky 2nd, 3rd and 6th graders throughout the Commonwealth. Targeted schools have an increased number of Medicaid eligible children. Parents were informed on the program through informed consent signature forms College of Public Health.
• With funding received from the Oral Health Collaboration Systems Grant (MCHB/HRSA) for a state-wide Oral Health Strategic Planning process, the Kentucky Oral Health Strategic Plan was published and distributed in the spring of 2006. Numerous areas of oral health needs for Medicaid and KCHIP eligible children and suggested initiatives for reducing these needs were identified in the strategic plan.
• The HANDS Home Visitation Program stressed the importance of oral health to overall health for Kentucky's children and their families during HANDS services to over 10,967 Kentucky families and completion of 137,230 (over 11,000 a month) home visits.

Student and staff volunteers from Kentucky's two dental schools, University of Kentucky and the University of Louisville, dental hygienists schools, staff from the Kentucky Oral Health Program and Kentucky Dental Association volunteers provided oral health screenings, sealants, fluoride varnish and education to children at the Kentucky State Fair.

The collaboration, known as the Kentucky Dental Public Health Partnership, was awarded the

American Public Health Association/Glaxo SmithKline Partnership for Healthy Children Award at the 2006 American Public Health Association's 13th annual meeting. This award recognizes and supports community-based collaborative efforts to improve the health of children.

Kentucky is in its final year of the Oral Health Collaboration Systems Grant (MCHB/HRSA), which funded a state-wide Oral Health Strategic Planning Process and an on-going Children's Oral Health Surveillance System for the state.

KOHP and Health Care Access Branch staff continues to collaborate regarding the application for Dental Health Professional Shortage Areas in Kentucky. Currently there are 17 Dental Health Profession Shortage Areas in Kentucky, 12 of which are located in the Appalachia.

Eighty-five Second Year students at the Pikeville College of Osteopathic Medicine completed 4 days of Oral Health training.

Fluoride varnish is now part of the Medicaid Preventive Health package.
31,103 fluoride varnishes were provided in local health departments and Commission for Children with Special Health Care Needs Regional Clinics in 2007.

The unanimous vote for passage of House Bill 186 in 2008 demonstrates a strong commitment to oral health from Kentucky's legislature. The bill requires public school students receive a dental exam within 90 days of first-time enrollment and will be fully implemented for the 2010-11 school year.

For 2008, 39,875 Pre-packaged fluoride varnish kits were provided to local health departments and Commission clinics. Fluoride varnish is now part of the Medicaid Preventive Health package. 10,518 fluoride varnishes have been provided from January through June 2008 in local health department and Commission clinics.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	9.2	7.7	9.5	9.8	10.8
Numerator	1828	1699	2176	2255	2468
Denominator	19888	22161	22902	22902	22902
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
Though the Commision no longer offers separate programming for children receiving SSI benefits we will continue to document services to SSI eligible children and youth who qualify for services in the CSHCN medical program. The Commission will also continue to partner with the Social Security Administration and Disability Determination Services to provide outreach and referral information to families who apply for SSI disability benefits for children or youth under age 16. Families of young SSI recipients and youth under age 16 who receive SSI benefits may contact

the Commission at 1-800-232-1160 or by email from the agency website: CCSHCNWebPage@ky.gov, for assistance in locating resources to meet medical or rehabiltative needs that are not covered under Title XIX-Medicaid. The Commission served 8.19% (1,631) of children and youth under age 16 who receive SSI benefits in Kentucky.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	10.6	7.6	9

Narrative:
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. The comparison data is obtained from payor source information on KY Birth Cetificates. Data Linkage between Vital Statistics and Medicaid for this Health System Capacity Indicator has not been achieved.

KY Low Birth Weight (LBW) rate is slowly rising. Our strategies for attacking this problem include:

HANDS home visiting program - evaluation showed decrease in LBW infants in high risk first time moms receiving HANDS services, and no VLBW infants in the served population. Several pilot sites are working on expansions of the HANDS program to include more than first time moms, and follow the infants longer than the first 2 years of life (which should help increase the intervals between pregnancies)

Medicaid is planning a case management program for pregnant women. Half of the women with low birth weight babies are on Medicaid, so this has the potential to have significant impact.

Centering Pregnancy -- Kentucky has one hospital who has moved to all Centering Pregnancy for low risk prenatal care. A second Centering Pregnancy program is at the Bluegrass High Risk Obstetrics Clinic at the University of Kentucky, which serves a large number of Hispanic mothers. KY has sponsored several workshops already and we hope to have several other centers to pilot this new approach to prenatal care within the next 12-24 months.

In 2008, the Healthy Start Program will continue to:
• Increase the number of disparate populations seeking services particularly African-American pregnant clients
• Reduce poor pregnancy outcomes such as low birth weights
• Increase the number of women initiating prenatal care in the first trimester
• Increase the number of women receiving preventive care services after delivery
• Zero infant mortality to Healthy Start Participants

Preconception Care - new initiative to improve pre-pregnancy health and therefore to have an impact on birth outcomes. Family Planning clients are provided counseling annually to promote preconception health. We are currently reviewing our protocols for services to women in health departments to assure alignment with Preconception Care strategies. Counseling in the health departments supports the recent CDC recommendations for preconception health and includes:
• Eat a variety of foods from each food group

• Take 400mcg of Folic Acid daily to help prevent birth defects of the brain and spinal cord
• See your dentist regularly to prevent dental infections and tooth decay
• Keep yearly routine medical visits up to date, including a complete medical history, laboratory screening tests, updated immunizations, and a physical exam that includes a cervical cancer screening to detect early precancerous conditions of the cervix
• Check your home and work for any environmental substances (i.e. lead exposure) which could prevent normal growth of the fetus as well as physical and mental defects
• Stop drinking alcohol, smoking and taking drugs
• Exercise 20 minutes 3 or more times a week to help reduce the risk of heart attacks, strokes, high blood pressure, obesity, osteoporosis (brittle bones), and arthritis
• Vaccinate before you become pregnant, as it will protect your future children from harm
* All women receiving family planning services are screened on the health risk assessment for depression, thoughts of suicide or harming others

Kentucky was selected as the only state in the nation to partner with National March of Dimes and Johnson & Johnson Pediatric Institute in a $1.5 million initiative, "Healthy Babies are Worth the Wait" Prematurity Prevention Partnership. The 3-year partnership, formed in 2006, is designed to prevent 'preventable' preterm births in targeted areas of Kentucky by 15 percent by utilizing evidence-based clinical and public health interventions. The goal is to maximize all of the services in the community that can help lower the rates of preterm birth. The interventions include raising public awareness about preterm birth, provider education about new research information, patient safety strategies, and enhancing patient referrals to services in the community that improve birth outcomes. Six hospitals representing diverse geographic regions of the state will take part in the project. These hospitals will be divided into intervention and comparison sites for the length of the partnership. King's Daughters Medical Center in Ashland, Trover Clinic/Regional Medical Center in Hopkins County and University of Kentucky hospital in Lexington will serve as intervention sites, employing targeted practices of clinical care, public health and public education. Lake Cumberland Regional Hospital, Somerset, Nortons Hospital in Louisville, and Paducah's Western Baptist Hospital will serve as the comparison sites, providing their traditional high quality perinatal services and care

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	payment source from birth certificate	6.8	4.2	5.3

Narrative:
Kentucky's infant mortality rate is on a slow but steady decline. However, there remain large discrepancies in infant mortality by race, consistent with national data. The Healthy Start project in Louisville, where our largest African American population lives, has been very successful in improving outcomes in disparate populations.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	61.1	79.4	71.3

Narrative:
The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. This could be a possible reason for the decline observed.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	67.6	80.4	74.5

Narrative:
The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. This could be a possible reason for the decline observed.

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and for all MCH populations in the State. The comparison data is obtained from payor source information on the

Birth Cetificates. Data Linkage between Vital Statistics and Medicaid for this Health System Capacity Indicator has not been achieved.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	200

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	185

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	185

Narrative:
Medicaid/Chip Eligibility Levels (Form 18). Please see data included within the HSCI section for levels for children and pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2009

Narrative:
Currently, the Division of MCH has the ability to access many types of maternal and child health data through the work of Epidemiologist, Tracey Jewell, MPH. Ms. Jewell works analyzing vital statistics data, service data (through the Patient Services Report System -- local health department service/payment data), Kentucky Birth Surveillance Registry (KBSR) data and Family

Planning Annual Report (FPAR) data and other information as needed. Ms. Jewell has direct access to Vital Statistics Data and can obtain data from Hospital Discharge Database, WIC and other databases.

We are beginning to link Vital Statistics live birth certificates on an annual basis to death certificates. Ms. Jewell has direct access to all electronic files regarding vital events for Kentucky. The birth and death records are linked through the process of running a SAS program that links death certificates to birth certificates based on pre-defined variables and criteria. We still need to refine this process in order to achieve data linkage >97%. This process creates a temporary SAS dataset from which detailed analysis can be performed on linked records.

A major IT focus in Kentucky is the development of KBirth by which birthing hospitals would utilize one system for electronic reporting of live birth certificate information as well as newborn blood spot screening data and newborn hearing screening data. The project is operational at all birthing hospitals in the state. Future efforts of the SSDI grant will focus on utilizing the referral system developed for KBSR to facilitate the referral of individuals identified with hearing loss through the newborn hearing screening program to First Steps for early intervention services.

Data Linkage Activities:

The Division of Maternal and Child Health (MCH) has been working closely with the Office of Vital Statistics from the Division of Epidemiology and Health Planning to create and sustain a consistent approach to linking infant death certificates to their corresponding certificate of live birth thereby creating a permanent linked data set of infant death records to birth certificates. This task has been undertaken by the data analyst from the Office of Vital Statistics, the senior Epidemiologist from the Division of Epidemiology and Health Planning, an Epidemiologist with the MCH branch, and the senior MCH Epidemiologist. This workgroup met several times to formalize a plan and develop a linkage algorithm for testing to be utilized in creating the official linked file for KY.

An initial SAS program was developed by the workgroup and tested by all four group members. The program code was modified as appropriate to ensure all possible links were captured. The algorithm links the certificates in a two step process first linking on the birth certificate number followed by the infant's first and last name, gender, and date of birth. The linked data is reviewed for accuracy and those records that did not link are being matched through a hand-match process. The Office of Vital Statistics is also creating a linked file based on the paper certificates that are received in the office. Once the death certificate of an infant is received vital statistics staff verifies the child's corresponding birth certificate number and write it on the death certificate. These records are then entered into an electronic database which is updated on a monthly basis.

The electronic database created by Vital Statistics is being utilized to cross-check the data linkage algorithm developed by the workgroup. Linked data from both systems are being compared to determine if all possible links are being captured by both methods. Once a thorough review of both methods has occurred, the workgroup will meet to discuss the results and make any necessary adjustments to either system as needed. The SAS linkage algorithm will continue to be used to monitor and validate the linked file being created in vital statistics.

In addition to the on-going linkage of birth and infant death files, the MCH Epidemiologist has recently gained access to the Medicaid Claims database for Kentucky from the Department for Medicaid Services and is currently working with Medicaid to learn the system. Several data elements and indicators have already been obtained from the system and the data is being used in various reports and projects. On-going access to the Medicaid system is anticipated to continue by both parties involved and data will be continued to use in a variety of ways in the future.

The MCH Epidemiologist also obtained recently access to the Kentucky In-Patient Hospital

Discharge Database from the Office of Health Policy and is currently working with staff from Health Policy to learn the system. The data is being used for various indicators and reports and access to the system is expected to continue in the future.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco survey	3	No

Notes - 2009
An attachment is included in this section.

Narrative:
Data from the most recent Youth Risk Behavior Survey (YRBS) show that fewer Kentucky high school students are engaging in negative behaviors than in 2003.
The data was gathered in 2007 through the U.S. Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance Survey. The YRBS measures what the CDC defines as the Six Critical Health Behaviors of Adolescents:
•alcohol and drug use
•injury and violence (including suicide)
•tobacco use
•nutrition
•physical activity
•sexual risk behaviors

Developed in 1992, the YRBS includes national, state and local school-based surveys of representative samples of 9th- through 12th-grade students. These surveys are conducted every two years, usually during the spring semester. The national survey, conducted by CDC, provides data representative of high school students in public and private schools in the United States. The state and local surveys, conducted by departments of health and education, provide data representative of public high school students in each state or local school district.
In Kentucky, the YRBS is given to a randomly selected sample of high school students. The data is reported as statewide totals only.
Tobacco Use
• The percentage of students who ever tried cigarette smoking has decreased from 71.1% in 2003 to 62.2% in 2007.
• The percentage of students who smoked cigarettes on school property on one or more of the past 30 days has decreased from 14.3% in 2003 to 9.5% in 2007.

Smoking in middle school and high school students in Kentucky is decreasing.

This is the results of many efforts, including:

Tobacco Prevention and Cessation Program is funded by the Tobacco Master Settlement Agreement (MSA) and a grant from the Centers for Disease Control and Prevention (CDC). Local health department staff teaches prevention education in schools, provides smoking cessation programs, conducts community assessments, offers technical assistance to schools and businesses, and develops coalitions to promote and provide community interventions related to

tobacco use.

Youth Advocacy Trainings: Raising youth awareness about smoking hazards and the impact students can have on reducing exposure
• Coordinated School Health Initiative (Kentucky Department for Public Health and Kentucky Department of Education) and the Tobacco Prevention and Cessation Program which are both funded through the Centers for Disease Control and Prevention, jointly planned and conducted regional conferences with the Pike County Health Department through Kentucky's ALERT Regional Prevention Center to raise awareness on tobacco-related issues and to increase capacity for youth advocacy efforts in tobacco use prevention.
• Students learned how to organize a public awareness campaign and to contact elected officials. These teens then organized and led other teenagers to spearhead a petition campaign, ultimately gathering 4,000 signatures in support of a smoke-free ordinance for the Pike County Fiscal Court and Hall of Justice Buildings.
• Representatives from the health department in Pike County, the American Cancer Society, and other groups provided support by offering smoking cessation classes for those affected by the proposed smoking ordinance.
• Students gain confidence and skills by applying their knowledge about tobacco to a project that also helps their community.
• Youth from Kentucky's 4-H Team Leadership Councils participated in a local Help Overcome Tobacco Youth Conference.
• These efforts became a positive model for students and communities in Kentucky on their citizenship role in working together to achieve a healthier community.
• Integrating functions of two federally-funded programs maximized benefit and used program resources wisely.

Currently, 100% of local health departments coordinate teen smoking prevention activities, including teen smoking cessation activities and are working to assist adults (particularly pregnant women) with smoking cessation efforts. Some of the programs being used through the public health system in Kentucky are LifeSkills, The Cooper/Clayton Method to Stop Smoking, Make Yours a Fresh Start Family, TEG/TAP, NOT (Not On Tobacco), and TATU (Teens Against Tobacco Use).

IV. Priorities, Performance and Program Activities

A. Background and Overview

Since the Public Health Improvement Plan in 1998, the Department for Public Health has maintained a strong emphasis on data for assessment of our strategies. The Public Health Improvement Plan from 1998 identified the following priorities:
-Teenage pregnancy and low birth weight babies
-Infant death
-Deaths due to heart disease, cancer, and stroke
-Health issues related to a rapidly growing elderly population
-Immunizations for children
-Disability and premature death of children and youth
-Lifestyle activities, including physical fitness and exercise, nutrition, sexual practices, use of tobacco, alcohol, and illegal substances, and seat belt use
-Prenatal care for pregnant women
-Access by both private and public health providers to health and health-related information
-Environmental health standards
-Food safety
-Communicable diseases

Kentucky DPH continues to monitor Performance Measures and related measurable health outcomes on a regular basis. March of Dimes Peristats data, BRFSS, Healthy People 2010, Healthy Kentuckians 2010, state vital statistics data, Medicaid data, and WIC data are used as baseline data to develop program goals, objectives and strategies and then to track health outcome indicators. Data analysis is an integral part of Kentucky's MCH program evaluation process, and the Title V Block Grant National and State Performance Measures are critical to that process. A concerted effort was made to provide detailed program information for each activity that addresses a national or state performance measure.

/2007/ The Kentucky Department of Public Health conducted a Mid-Decade Review of the Healthy Kentuckians 2010 report. Among the HP 2010 MCH indicators where KY has shown progress are:
-decreasing infant mortality
-decreasing fetal death rate
-decreasing perinatal mortality rate
-increasing early entry and adequate prenatal care (prior to change in data source)
-increasing proportion of mothers breast feeding
-lowered incidence of neural tube defects
-increased percent of women taking folic acid
-increased the number of pregnant substance abusers admitted into treatment programs
-reduced the number of children with serious neurological/sensory impairments
-increased the number of newborns screened for hearing disorders.
-increased the use of child restraints (kids <4)
A summary and the full report may be viewed at chfs.ky.gov/dph/hk2010MidDecade.htm //2007//

/2009/ Kentucky's priorities continue to be the health, safety and well-being of women, infants and children. The priorities are much the same as in the last 10 years. However, after review of the data, we are acknowledging that there has been little improvement in the health of Kentuckians despite our efforts, which have included large scale promotion of evidence-based strategies to address issues at the community level. Dr. Hacker has therefore selected a limited number of topics to be our primary focus, although no current programmatic area will be ignored. The topics selected for emphasis will be 1. Unhealthy lifestyles - primairly related to obesity and physcial activity 2. Tobacco use, including smoking during pregnancy; 3. Mental health issues including suicide and substance abuse, 4. preventable injuries (leading cause of death age 1-44), and 5. Oral Health.

Details of these efforts are provided in the measures throughout this grant.

The Department for Public Health is already participating in regional meetings regarding the development of national 2020 objectives, and those that are relevant will help set the priorities for Kentucky in the future. //2009//

Both the Commission for Children with Special Health Care Needs and the Department for Public Health welcome questions from readers. Contact information for the main offices of both agencies are listed below. Upon receipt of your call, you will be connected to the appropriate staff.

Kentucky Department for Public Health, Division of Adult and Child Health Improvement 502-564-4830

Kentucky Commission for Children with Special Health Care Needs 502-595-4459

B. State Priorities

State-Level Priorities

Kentucky began its efforts to combat obesity in 2004 with a series of community forums around the state.
The top six priorities from these forums were:
1. Provide mandatory physical education for K-12
2. Increase healthy choices in vending machines
3. Improve worksite policies to allow time to exercise, health seminars, and flex time
4. Provide more safe walkable communities and bike paths
5. Provide more staff for breastfeeding support
6. Lower the cost of fruit and vegetables

These were compiled with relevant data into a burden document for the use of legislators and administrators. the second step in the process was a state plan to address obesity and physical activity, which was produced in 2005. The plan was developed through a collaborative partnership of community and state level persons interested in promoting obesity prevention and physical activity. This group, teh "Partnership for a Fit Kentucky", continues today. More information can be found on their web site.
These issues were disseminated and supported by a Governor-appointed board, the "Get Healthy Kentucky" board. The work of this Board and other advocates resulted in passage of Senate Bill 172 in the 2005 General Assembly which has improved Kentucky's school nutrition. Kentucky was recently identified as having the best school nutrition policy in the United States by the Center for Science in the Public Interest's (CSPI). The CSPI evaluation of policies for foods and beverages that are sold in schools through vending machines, school stores, fundraisers and a la carte lines gave Kentucky the only "A" in the nation. This is complimentary with the federal efforts that require every school district that participates in the federal school meals programs to enact a wellness policy, which includes goals for nutrition education and physical activity, by the 2006-07 school year.
Through a collaborative effort among the Tobacco Control, Physical Activity, Obesity Prevention, and Coordinated School health staff, a guide for school administrators was developed and distributed by the Kentucky Department of Education. The "PANTA" Guide covered school assessment, evidence-based strategies, resources, and policy development for Physical Activity, Nutrition, Tobacco, and Asthma.

In 2006, the Governor created an Office of Wellness and Physical Activity (GOWPA), pulling the Public Health programs and personnel for those issues into a single unit. This group developed a web site to engage Kentuckians similar to the President's Challenge, as well as continuing the activities of each of the programs.

/2009/ After the change in administrations, the GOWPA group was moved back to Public Health into the Chronic Disease Prevention Branch of the Division of Prevention and Qualtiy Improvement.

The new Cabinet Secretary, Secretary Miller, and Dr. Hacker both have an interest in moving the empahsis to prevention of childhood obesity. Dr. Hacker attended a recent CDC summit on Obesity Prevention and the Law. Staff are working with Save the Children Organization for a summit on Childhood Obesity in Kentucky later this summer. Dr. Hacker and Representative Wuschner have obtained grant money from the National Governor's Association to host a summit on childhood obesity in the spring of 2009 aimed at the legislative and policy level. //2009//

The CCSHCN participates in numerous public education initiatives that address childhood obesity. A Commission employee sits on The Partnership for a Fit Kentucky planning committee which focuses on promoting good nutrition and encouraging communities to become physically active. The WE CAN! Initiatve is an outreach program designed to reach children 8-13 years of age and their parents. Recently, we have partnered with Pennyrile Allied Community Services, Inc. to provide a monthly newsletter that promotes healthy lifestyles. ***//2009//***

The Tobacco Program's mission is to reduce the amount of disease and the number of deaths related to the use of tobacco among Kentuckians. Initiatives are based on the CDC Best Practices for tobacco control: preventing youth initiation, promoting quitting among adults and young people, eliminating exposure to secondhand smoke, and identifying and eliminating disparities among population groups disproportionately affected by tobacco use. Efforts began with Community Forums on Tobacco Use in Kentucky, August 2005 -- November 2005; from those forums, the top five priorities for the state were:
1. Smoke-free ordinances
2. Increase the excise tax
3. Tobacco-free schools (100% tobacco-free campuses including extracurricular activities, buses, and athletic fields)
4. Insurance coverage for Nicotine Replacement Therapy (NRT) and prescription pharmacotherapy, tobacco cessation counseling and programs
5. Smoke-free worksites
Many initiatives have followed since these priorities were set. Kentucky currently has 17 communities with smoke-free ordinances. Patients/clients who are seen in any of these programs were screened to identify those using tobacco: Prenatal; Family Planning; HANDS; WIC; Nutrition; Adult preventative care; Pediatric Preventative care (Well Child); and Cancer. Every LHD continues to offer smoking cessation programs/classes, that are available to anyone referred by self or from doctor's offices or other community agencies.

Free nicotine replacement therapy was provided for Medicaid recipients who were actively enrolled in counseling with Kentucky's Tobacco Quit Line. The Pilot was a joint project between Medicaid, Public Health and the Tobacco Program. Project period is March 1-December 31, 2007. Preliminary data show a 66.84% quit rate at one month. Evaluation will include quit rates for 3 months, 6 months, and 1 year.

Kentucky's Tobacco Quit Line 1-800 QUIT NOW. The Kentucky Tobacco Quit Line is an evidence-based tobacco treatment program and wonderful resource for the Commonwealth. The Quit Line offers individualized cessation counseling for all tobacco users, including spit and chew tobacco, and a specialized protocol for pregnant women who smoke. English and Spanish language counselors are available. A TDY/TDD toll free number is available for individuals who are deaf and hard of hearing: (800) 969-1393. The Quit Line also provides referral information to connect callers with people in their community who can help, such as local and district health departments.

Legislation passed for Medicaid to cover counseling and pharmacotherapy, however, has not been implemented due to funding.

The Tobacco Program engaged partners to develop the Hospital Inpatient Tobacco Treatment Pilot to increase inpatient treatment for tobacco use. Partners are American Heart Association, Kentucky Hospital Assn, Kentucky Cancer Program (University of Louisville), and Healthcare Excel. Components include a baseline survey of hospitals, the selection of 5 pilot hospitals; standing orders for nicotine replacement therapy and other pharmacotherapy, standardization of materials and referrals, and evaluation.

Among all women 18-44 in Kentucky, around 29.7 % (2004) are smokers with a National Median of 22.8 % in 2004, while overall 23.9 % of Kentucky's pregnant women are smoking during pregnancy, so there is some impact of the message not to smoke during pregnancy.
Kentucky has the second highest rate of women who smoke during pregnancy, 23.9 %, compared to the national average of 10.7 %. Only West Virginia has a higher rate. Our lowest rate by county was 11.7 %, still above the national average. Our highest rate for a county was 45.8 %. Rate of smoking in pregnancy has not changed significantly over the last 10 years. The MCH and Tobacco Control program are partnering in new initiatives to address smoking in pregnancy. (see NPM 15)
Provided Treating Tobacco Use and Dependence and Treating Tobacco Use and Dependence during Pregnancy self-study kits to Kentucky physicians, dentists, nurse practitioners/midwives, physician assistants, dental hygienists and psychologists upon request.

Tobacco Program staff are ex officio members of the KY Medical Association, Committee on Community and Rural Health and have completed several projects with Committee members. The projects are designed disseminate information and to assist physicians in counseling patients.

/2009/ Due to Kentucky's financial distress, Governor Beshear proposed during the budget talks that Kentucky raise the tax on cigarettes to $.75 - still much lower than the national average, but hight than our current tax. This proposal was supported by a number of editorials and advocacy groups, but failed to pass the legislature. We are hopeful it will be raised as an issue again. //2009//

State MCH Priorities

Kentucky is building its MCH capacity for data collection and analysis in order to support data-driven and evidence-based decision making. Staff development through trainings, and skill building thru projects are a priority. A number of initiatives to that end are underway:

PRAMS

Kentucky submitted an application submitted to the CDC for PRAMS in 2007 but was unsuccessful. However, through a local March of Dimes grant and other funding, Kentucky was able to develop a pilot project but KY. The surveys began in fall 2007 and ended in spring 2008. This data will assist MCH and other staff to develop and implement program policies and strategies.

ECCS Grant

The Early Childhood Comprehensive Systems grant examines current services and identify potential service gaps within five areas Early Childhood Development; Health Insurance/Medical

Home; Mental Health/Social-Emotional Development; Early Care and Education Child Care and Parent Education and Family Support. Each subcommittee will meet to discuss issues and provide recommendations.

/2007/ The Early Childhood Comprehensive Systems grant is currently in its first year of implementation. The efforts for this implementation year are focused on filling identified "gaps" in services to young children within the existing KIDS NOW Initiative. Kentucky's Early Childhood Mental Health Program was showcased in a workshop at the AMCHP Annual Conference in March 2006. This program has been identified as a "model program" for early childhood mental health services. To date, the majority of activities listed in the grant have been completed. //2007//

/2009/ The Early Childhood Comprehensive Systems grant is currently in its final implementation year. The efforts for this implementation have focused on filling identified "gaps" in services to young children within the existing KIDS NOW Initiative. The funds from this grant have successfully carried out the mission of the Healthy Child Care America program by maintaining 1.5 FTE statewide trainers for childcare health consultation. Furthermore, the SECCs funds have been instrumental in securing early childhood mental health training and supervision, along with data collection and evaluative efforts around KIDS NOW programming. The programs supported through this grant will be sustained and funded through the Kentucky KIDS NOW initiative. //2009//

SSDI grant

/2008/ Kentucky completed a competitive grant renewal for the State Systems Development Initiative (SSDI) grant this year, and received funding for a total of five years. This grant has two major goals: 1) To increase collaboration and data capacity within the Department for Public Heath through data linkages and data integration of selected early childhood programs; and 2) To increase maternal and child health epidemiologic and health informatics capacity within the Division of Adult and Child Health Improvement for the purpose of improved surveillance and analysis of selected early childhood outcomes as well as program evaluation. Kentucky continues to provide funds through a contractual relationship with the University of Louisville, School of Public Health and Information Sciences for the purpose of data linkage and integration support of selected early childhood systems. A great deal of effort has been focused this year on the linkages within the Kentucky Birth Surveillance Registry (KBSR). This data system integrates hospital discharge data and vital statistics data (live births, stillbirths and deaths) to monitor the occurrence of birth defects in the Commonwealth of Kentucky. In 2004, the live birth certificate was changed in Kentucky, and these linkage efforts have focused on incorporating this new certificate and its additional fields within the KBSR system. An abstract describing these linkage efforts are being submitted for the 2007 Maternal and Child Health Epidemiology Conference.

In the upcoming year, the SSDI will continue these projects and begin to link Vital Statistics data with the HANDS (Health Access Nurturing Development Services) Home Visitation Program and First Steps. In addition, a quality assurance program for the Kentucky Birth Surveillance Registry will be developed and piloted. //2008//

/2009/ SSDI funds have also been utilized to hire an epidemiologist in the Division of Maternal and Child Health. This individual will collaborate with the University of Louisville staff on data linkages. In addition, this individual has organized a Pregnancy Risk Assessment Monitoring System (PRAMS) pilot project in Kentucky.

In the upcoming year, the SSDI grant will continue focus on linking Vital Statistics data with the HANDS (Health Access Nurturing Development Services) Home Visitation Program using Link Plus, and, if succesful, develop a similar linkage for our Part C Early Intervention program. In addition, the University of Louisville will be providing training on

statistical methodology and its application including familiarity with SAS for state staff. //2009//

Epi Capacity

/2008/ A memorandum of agreement was negotiated with the Centers for Disease Control and Prevention for a Senior MCH Epidemiologist assignee. We have also reclassified an existing position in the Early Childhood Development Branch to an Epidemiologist I position. The availability of trained staff to complete data analyses and evaluate program effectiveness will significantly improve the programs within the Early Childhood Development Branch. //2008//

/2009/ Although it was expected that a Centers for Disease Control and Prevention (CDC) Senior MCH Epidemiologist assignee was going to be assigned to Kentucky, this has not occurred to date. There have been barriers in completing the hiring process, and it is unknown at this time if the paperwork issues will be worked out to place this individual in the Division of Maternal and Child Health. Dr. Ruth Ann Shepherd, Division Director of Maternal and Child Health continues to communicate with the potential assignee and the CDC to monitor progress. //2009//

Other MCH Priorities/ Program Activities

Preterm Birth

"Healthy Babies are Worth the Wait" is a 3 1/2 year initiative begun by the Department for Public Health in 2007. This is a partnership with National March of Dimes and Johnson & Johnson Corporate Contributions, who are not only funders, but major participants in the project. The design is a "real world", ecological design as a demonstration project, not a linear cause and effect study. We have identified 3 intervention sites with geographic diversity and different health care settings (university, private practice, and clinic-based) in order to achieve 1200 births in the three years. The outcomes from these sites will be compared with 3 similar sites where we do no intervention. The intervention is multidimensional, taking evidence-based practices to prevent preterm birth, and link elements of clinical care, public health, and consumer & public education in the intervention communities. The target, based on Kentucky's data analysis, is late preterm birth (34 0/7 weeks to 36 6/7 weeks), and the elements of preterm birth that may be preventable. The goal is a 15% reduction in preterm birth in the intervention sites. More information can be found at the web site www.prematurityprevention.org.

Perinatal Depression

The Kentucky HANDS program was awarded one of 5 HRSA grants to study perinatal depression, and will be completing that project this year. Kentucky was ideal for this grant, as we had the infrastructure in place with the HANDS program working directly with patients, and the Early Childhood Mental Health program that had developed the skills and capacity of mental health professionals in each region to address mental health needs in pregnant women and infants. The HANDS visitors are using the Edinburgh Perinatal Depression Screening tool at three times during the perinatal period. Those who screen positive are referred to a specifically trained mental health professional in the region. Data is being collected in a web-based system.

/2009/ Children Ready to Read for Health

The program Children Ready to Read for Health works with pediatric health care providers including local health departments, pediatricians, and Family Practice providers to help raise pre-reading skills among young children of low income, so they begin school ready to learn. Children Ready to Read for Health promotes language and literacy by giving parents guidance about reading aloud to their children and providing developmentally

appropriate books to take home at each pediatric visit from 6 months to 5 years. Age-appropriate books and parental advice on book sharing are given by nurses and doctors. The program provides training and ongoing technical assistance in the implementation of this early literacy program. Early reading has been shown to improve children's ability to express themselves verbally, increase listening vocabularies, and reduce language delays. Research shows that 16% of parents of children age three years and younger do not read at all with their children, and 23% do so only once or twice a week; percentages are even lower among low-income families, whose children face the highest risk of literacy problems. Reading difficulty contributes to school failure, which increases the risk of absenteeism, leaving school, juvenile delinquency, substance abuse, and teenage pregnancy, all of which perpetuate the cycles of poverty and dependency.

According to KY Kids Count, 21% of children born in Kentucky are born to mothers that have not attained a high school degree and 21% of all children are in poverty. This program provides information to parents and caregivers about the value of reading to their children. Families living in poverty often lack the money to buy books. Parents who may not have been read to as children themselves may not realize the tremendous value of reading to their own children.This program will support local, community-based efforts to enhance the early language, literacy, and prereading development of preschool-age children, particularly those from low-income families, through strategies and professional development that are based on scientifically based reading research.

Research has found that higher levels of reading and literacy help reduce education costs for special education, decrease costs of unemployment and low wages, decrease health care costs and decrease crime costs. Adults with higher literacy levels are more likely to be employed full-time and less likely to be out of the labor force than adults with lower literacy levels. Higher literacy correlates with the percentage of adults employed in professional and related occupations and management, business, and financial occupations than in other occupations. Women with higher levels of literacy are less likely to receive public assistance than women with low levels of literacy. Additionally, enhanced early childhood intervention programs have been found to save 4 dollars for every 1 dollar spent. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	95	95.5	96	98	98
Annual Indicator	96.3	83.6	98.4	98.5	98.3
Numerator	53381	46	380	536	530
Denominator	55413	55	386	544	539
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99.5	99.5	99.5

Notes - 2007
2007 data is preliminary.

Notes - 2005
2005 data is preliminary and not all cases may have been reported yet, therefore, the rate could change.

a. Last Year's Accomplishments
This program administers the newborn metabolic screening for all infants born in Kentucky. All newborns in Kentucky are screened for metabolic and genetic conditions that can have serious adverse outcomes if untreated early in life. Early detection, diagnosis and treatment of children with these rare metabolic conditions may prevent a child's death, disability, or serious illness. In 2006 newborn screening in Kentucky was expanded to include the full panel of 29 tests for inborn errors of metabolism and other inherited disorders, recommended by the American College of Medical Genetics and the March of Dimes.

The newborn screening follow-up team consists of a nurse administrator, two nurse consultants and a program coordinator. Newborn screening tests are performed by the Kentucky Department for Public Health, Division of Laboratory Services. Follow-up for positive screens is coordinated by the newborn screening follow-up team in the Division of Adult and Child Health Improvement. This team assures follow-up of all abnormal screens for definitive diagnosis and treatment for inborn errors of metabolism and inherited disorders included on the newborn screen. Short term case management is carried out by follow-up staff using the infant's primary care provider as the medical home to coordinate definitive diagnosis. This staff has been cross-trained to work with the birth defects registry as well.

Additionally, contracts exist with both the University of Kentucky and the University of Louisville Medical Centers to provide medical consultation. Upon receiving a confirmatory diagnosis of the screening result, the university medical centers engage in patient/family education, medical management and training throughout the state. Formula and food products, as well as supplements are also provided for individuals with metabolic conditions when a third party payer source is unavailable.

A new data system for the Newborn Screening program was developed and implemented January 1, 2007, within the Cabinet for Health and Family Services that interfaces with the vital statistics electronic birth certificate at the birthing hospitals. The case management segment of newborn screening has been developed as part of the KY-CHILD Electronic Public Health Record Set. The birthing hospital enters the demographic information and prints a label to affix to the newborn screening specimen collection card and mails to the state lab for testing. The demographic information is interfaced with the Newborn screening case management system for case management of infants with abnormal screening results.

Educational trainings for providers on the newborn screening and specimen collections have been updated this year and made available on-line. On-site trainings and education have also been provided. The newborn screening team worked with the Kentucky Chapter of the American College of Obstetricians/Gynecologists to encourage prenatal education regarding newborn screening to be completed in the last trimester. The program also worked with the childbirth educators throughout the state to incorporate newborn screening into the prenatal education. The DVD "A Parent's Guide to Newborn Screening" produced by the March of Dimes was purchased and distributed to all the birthing facilities for use in parent education.

902 KAR 4:030 established that each birthing facility designate a newborn screening coordinator to the Department for Public Health (DPH). This coordinator works with the follow-up staff to

assure that every infant born at their facility receives a newborn screen and appropriate follow-up.

Analysis of the newborn screening data looking at collection time and quality of specimen collection was performed. The newborn screening staff target provider education to address specific areas of concern to improve the timeliness and quality of the specimen with the facilities showing a need for this education. One of the largest birthing hospitals in Kentucky had an unsatisfactory rate of 14% for 2006, was targeted for education in January 2007, and the preliminary 2007 rate has improved to 1.8%.

The state laboratory implemented an improved testing method for hemoglobinopathies by using the high performance liquid chromatography (HPLC) method, which is more specific testing for the hemoglobinopathies.

2006 544 referred- 5 died prior to diagnosis and 3 Lost to follow-up. DPH does send out a parent brochure to any parent that refuses screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NBS Business Partnership to identify key issues			X	X
2. NBS Advisory Committee development and regular meetings			X	X
3. Consumer involvement (Parents and Adult Consumers) involved throughout all aspects of the NBS Program			X	X
4. Data system for the NBS program within the Dept for Public Health			X	X
5. The Newborn Screening program was expanded to 29 disorders			X	
6. The Tandem Mass equipment was purchased to expand NBS		X		
7. Training for State Lab staff on the Tandem Mass equipment				X
8. Increased training and expertise at the University Speciality clinics				X
9. DPH Has developed a Case Management system that follows a child through diagnosis and treatment				X
10. Parent Information and Fact Sheets available on the CHFS website	X	X	X	X

b. Current Activities

The KY-CHILD system is being integrated with the new PerkinElmer Specimen Gate system in the laboratory. The label that is printed and affixed to the newborn screening filter paper card will have a bar code. Upon receipt in the lab the card is scanned and the demographic information is electronically transferred over from KY CHILD to the lab system. This will decrease potential data entry errors as well as allow for reporting of infants that no screen in received by the lab.

Increase timeliness from specimen collection to receipt at the lab from an average of 5 days (2003 data) to 3 days statewide. Analysis of the 2006 data for timeliness of receipt of specimen showed that the 2006 average is 4.36 days, which shows improvement; continue to provide education and feedback to problem areas identified.

Establish a registry for the DNA mutations identified in infants diagnosed with Cystic Fibrosis (CF) from newborn screening. The state laboratory is establishing second tier testing for CF on the newborn screen to include DNA testing on the presumptive positive screens.

The program maintains updates for each of the 29 disorders, informational fact sheets and resources which were developed in 2006, one for health care providers and one for parents.

These education materials were also made available on the website http://chfs.ky.gov/dph/ach/newbornscreening.htm

2007 539 referred-4 deaths and 5 Lost to Follow-up. DPH does send out a parent brochure to any parent that refuses screening.

c. Plan for the Coming Year

902 KAR 4:030 established that each birthing facility designate a newborn screening coordinator to the Department for Public Health (DPH) and submit a newborn screening protocol annually. Only 88% have submitted protocols and many of these do not meet criteria. The newborn screening staff is working one-on-one with birthing facilities to develop a newborn screening protocol which assures that every baby born at that facility receive a newborn screening test.

Provide "grades" to the hospitals on the quality and timeliness of newborn screening testing based on their 2006 and 2007 data. Work with birthing hospitals on quality improvement regarding the newborn screening process at their facility to include establishing a protocol to assure every newborn receives a screen and the procedure for reporting if a parent refuses to allow screening. Establish preliminary prevalence rates for the newborn screening disorders for the 2006 and 2007data in Kentucky.

Develop a care notebook for parents of diagnosed infants. This care notebook would serve as a portable medical record for the parents with information about the disorder and treatment and other pertinent information about the infant.

The program is working with the early intervention program to establish a referral process for children identified through newborn screening as having an established risk condition that is automatically eligible for early intervention services. A letter will be developed that the universities can give to parents explaining the program and the services available for their child and contact information. The point of entry for early intervention will also be notified at the same time.

Reports and queries will be developed for the PerkinElmer laboratory information system to allow monthly reporting on quality and timeliness by facility allowing for more timely feedback after interventions are implemented to improve the newborn screening process.

The infants diagnosed as positive for disease through newborn screening will be fully integrated into the birth defect surveillance registry for long term tracking of these infants and future reporting. These will be imported into the birth defects registry upon completion of the annual reporting.

The HRSA Region 4 Genetics and Newborn Screening Collaborative received a new award for which will extend through the next four years and Kentucky will continue to participate in the initiatives of this grant.

Increase the percent of newborns screened to 99% from the current 98%. Analyze data for percent of newborns screened and establish baseline of number of screens that are refused by parents. Provide education to parents and hospitals on metabolic Newborn Screening and its importance to decrease the number of parents than refuse screening.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	61	63	65	67	67
Annual Indicator	53.2	61.3	65.1	69.3	64.1
Numerator	4267	5651	5560	6141	5261
Denominator	8025	9214	8543	8862	8206
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	68	69	70	70	70

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
PAC members participated in over 20 Commission employment interviews.
PAC members talked to legislators about the importance of passing a bullying bill.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Parent Advisory Committe established.		X		
2. Parent Consultants participating in emplyee interviews.		X		
3. Family members of Title V CSHCN serve on agency Board.				X
4. Commission Board members provide insight & direction on all decisions affecting CYSHCN.		X		
5. Youth Advisory Committee increasing involvement in advocacy.		X		
6. Parent Professional serves as family participation liaison.		X		
7.				
8.				
9.				
10.				

b. Current Activities
The Commission relies on its Board of Commissioners, Parent Advisory Committee (PAC) and Youth Advisory Committee (YAC) for insight into how best to address the concerns of the special

needs population. Board members are generally parents of a special needs child or children or practitioners with extensive experience treating this population.
The YAC have been encouraged to identify their concerns and with the Commissions guidance how to advocate on their own behalf. By providing an open and safe environment to explore their needs & concerns many YAC members have gradually found their own voice; they have become confident about the future and what they can accomplish.
Now that PAC members have completed the behavioral interviewing training all employment interviews include a PAC member. The PAC was also asked to develop a question related to family-centered care or family input that could be used in all interviews.
Both YAC & PAC reports are submitted to the Board of Commissioners for their review.

YAC members presented a panel discussion of their experiences of inclusion & exclusion as a special needs youth.
YAC members will work closely with VR to develop strategies to contact yshcn before their senior year.
PAC members are developing tools/skills for parent-to-parent teams.

c. Plan for the Coming Year
The Board of Directors will continue to provide guidance and insight in addressing the needs of the special needs population including our foster care support and medically fragile foster care programs.

The Board, PAC and YAC will be included in the planning process for the upcoming needs assessment.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	56	95	95	95	92
Annual Indicator	95.3	90.4	90.1	90.0	90.3
Numerator	7951	8327	7699	7976	7406
Denominator	8344	9214	8543	8862	8206
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	93	94	95	96	95

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
Commission staff continued to identify each client's PCP, input information into CUP and communicate to the PCP services provided during CCSHCN clinic visits.
Staff often help families navigate through several layers of comples health and education delivery systems. By encouraging families to work with school systems, providing specific guidance and hands-on support families seem to gradually understand the complexity of their child's educational issues and how it may relate to health issues.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data system identifies each client's PCP.				X
2. CCSHCN provides medical specialty care in collaboration with child's medical home.	X			
3. CCSHCN staff provide ongoing, comprehensive, coordinated care to children enrolled in the traditional program.	X	X		X
4. CCSHCN established a PCC to serve foster children in the Bluegrass ADD.	X	X		X
5. CCSHCN Lexington staff ensure all service needs are addressed in the Foster Care PCC and provide the necessary support.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Commission established a primary care center staffed by one pediatrician and an ARNP. The immediate goal is to provide services to the foster care population in the Bluegrass Area Development District (ADD) because access to care has been limited for Medicaid clients, especially foster care children. Funding for this initiative has been limited due to budget constraints but the Commission is pursuing other financing options. Office hours are 10 AM - 2PM M-F. After hour services are available.

In many ways the Commission serves as the medical home for special needs children enrolled in our program. While routine care may be provided by the PCP RNs & SWs are knowledgeable of available community resources and find inventive ways to address unusual needs. Both RNs & SWs must often help families navigate multiple layers of bureaucracies in order to obtain needed services or understand how recommended services relate to their child's health.

Improvements to CUP will enhance the ability for both the Commission and health care providers to communicate in a more timely manner.

c. Plan for the Coming Year
The CCSHCN plans to continue operating the Foster Care PCC and aggressively pursue additional funding.
Staff will continue to assist PCPs with identifying community resources to address a family's

needs. Once additional funding is secured the CCSHCN intends to make PC services available to foster children beyond the Bluegrass ADD.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	57	64.9	65	93	93
Annual Indicator	64.8	63.0	91.0	89.8	99.0
Numerator	6427	6247	7778	7962	8125
Denominator	9913	9913	8543	8862	8206
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	99	99	99	99

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
Commission Care Coordinators worked to become more knowledgeable about benefit levels and potential adverse effects on families when required procedures are not used.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Title V/CCSHCN staff document current status of each family's 3rd party resources.		X		
2. Care Coordinators trouble shoot problems with 3rd party payers when they arise.	X			
3. Educate families about their insurance benefits & how to access benefits when needed.		X		
4. Reinforce personal responsibility for self care and appropriate use of health care resources, including use of preventive care &		X		

family education.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Commission has focused its efforts on documenting the family's insurance carrier and helping families communicate effectively with their carrier when questions arise. Part of the application process often includes helping families understand their current benefit levels and why it's important to update the Commission about changes. Families assigned to the Commission's 60% pay category or who are receiving food stamps are required to apply for Medicaid if they have not done so. Staff may provide assistance to families unfamiliar with the Medicaid application process.

c. Plan for the Coming Year

Commission Care Coordinators, primarily RNs, will continue to work to become more knowledgeable about benefit levels and potential adverse effects on families when required procedures are not used.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective		77	78	93	93
Annual Indicator	76.9	81.2	91.1	89.8	88.0
Numerator	6170	7484	7781	7961	7221
Denominator	8025	9214	8543	8862	8206
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	93	93	93	93	93

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
Instructions for completing application forms were revised improve the successful completion rate.

Families with children who require services from a multi-disciplinary team during a clinic visit are scheduled to see all specialists on the same day.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff continue to identify local venues in which to provide needed services.	X			
2. Utilize mobile health unit to provide routine dental care.	X			
3. Coordinate health care and related services with foster care social workers.	X			
4. Accompany social workers on home visits for medically fragile foster children.	X			
5. Varied specialists needed to treat conditions that require a multi-disciplinary approach are scheduled for the same location on same day.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Commission staff in each regional office maintains current information about community-based resources in their region. While families must still make individual appointments for each service staff may provide guidance and assistance to ensure all necessary appointments are made.

Though dental health services to the Amish were suspended temporarly services have resumed.

c. Plan for the Coming Year
Families with children who require services from a multi-disciplinary team during a clinic visit will continue to be scheduled to see all specialists on the same day.

Commission staff will continue to maintain current information about community based services and how best to access those services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective	10	50	51	52	53
Annual Indicator	28.3	13.6	9.6	9.7	8.6
Numerator	503	1250	821	859	667
Denominator	1779	9214	8543	8862	7760
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	30	35	35	40

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2004 reflects the population 0 - 18 enrolled in Kentucky's CSHCN program receiving medical services; this program does not provide services to the larger number of youth that could be identified in the state using MCHB's broader definition of CSHCN. The numerator reflects those patients 0 - 18 receiving medical services who have discussed age appropriate transiton needs.

a. Last Year's Accomplishments
CCSHCN is the State title V partner in the MCHB funded National Health & Ready to Work Center
The Commission was actively involved in the Kentucky Interagency Transition Planning Council and the Regional Interagency Transition Teams.
CCSHCN placed an increasing number of cyshcn in one-on-one contact with employers during Disability Mentoring Day.
Commission staff was elected chaired the Statewide Council for Vocational Rehabilitation.
Commission staff was interviewed and later appointed to the Board of Directors for the Center for Accessible Living. Both SCVR and CAL are vital links for transitioning youth to work and independence.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Care coordinators & social workers utilize comprehensive transition checklist to assess client/family readiness to transition to adult life.	X			
2. Support the Youth Advisory Committee as they develop advocacy skills.		X		

3. Support the Parent Advisory Committee as they develop parent-to-parent skills and tool sets.	X			
4. Support both YAC & PAC as they develop skills and relationships with Voc. Rehab. and the Center for Accessible Living.		X		
5. Collaborate with community partners to address transition needs.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Transition services are addressed through one-on-one discussions with families enrolled in CCSHCN programs and by collaborating with community partners and encouraging participation from all members of the disabled community.

Once a family has completed the intake & eligibility process and is approved for services the Transition Checklist component of CUP is activated. The checklist is comprised of 2 primary sections, health skills and independence/school/work. Designated staff is required to document whether skills have bee accomplished, are a work in progress or part of future expectations.

Collaboration with special education resulted in a transition fair that gave youth the chance to participate in mock interviews, prepare a resume and a cover letter. CCSHCN staff also works with a local high school district in a WorkNet program designed to begin addressing work readiness before the senior year of high school. The Medical Reserve Corp provided guidance for emergency planning & preparedness. One CCSHCN regional office hosted Guardianship & Special Needs Estate Planning Workshop for all families in the district with a special needs child.

Commission staffs are always looking for and developing ways to addressing transition needs in their communities.

Commission asked the Youth Advisory Committee to identify transition issues important to them.

CCSHCN continues to partner with transition liaisons from the state's special education cooperatives.

c. Plan for the Coming Year

Staff plans to work with YAC members to develop strategies that address issues identified in the survey.

Commission staff will continue to use the transition checklist to address transition needs.

Commission staff will continue to work with families, schools (districts) and other community partners to identify & address transition needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	77	77	82	92	92
Annual Indicator	81	79.1	79.7	84	84
Numerator					
Denominator					
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	86	86	90	90	92

Notes - 2007
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data reflects year 2006, the 2007 data will not be available until sometime next year.

Notes - 2006
Numerator and denominator data are not available. Data is from the CDC NIP survey.

Notes - 2005
Numerator and denominator data are not available. Data is from the CDC NIP survey.

a. Last Year's Accomplishments
General Program Information - Immunizations in Kentucky

Within the Department for Public Health (DPH), the Division of Epidemiology and Health Planning is the lead division for the Kentucky Immunization program (KIP). Programs operated by DPH through the local health departments routinely assess immunization status. Immunizations are provided through the local health departments, private physicians, federally qualified health centers, and school based health centers.

A child's immunization status is assessed and referrals are made at many points within the health, education and social service delivery system. Specific programs within the Division of Adult and Child Health Improvement that effect this measure within preventive and primary services for children include the following: Regional Pediatrics Program; Child and Youth Project; Well Child Program; Health Access, Nurturing Development Services (HANDS); WIC; and Healthy Lifestyle Education.

Data for this measure is provided by the Kentucky Immunization Program (KIP) program data and by the CDC's National Immunization Survey (NIS). The NIS has been conducted annually since 1994 by the National Immunization Program and is used to obtain national, state, and selected urban area estimates of vaccination coverage rates for US children between the ages of 19 through 35 months. The NIS is a random digit dialing telephone survey of households with age-eligible children followed by a mail survey of the children's vaccination providers to validate immunization information. National vaccination rates are based on the entire survey sample of more than 30,000 completed interviews. The sample size for each state is considerably smaller and for this reason has a much larger confidence interval.

Annual Activities
The Department for Public Health supplies vaccines to local health departments and private providers enrolled in the Vaccines for Children (VFC) Program. The VFC Program is a national program that uses federal funds to provide vaccines free of charge to Medicaid eligible, uninsured, American Indian or Alaska Native and underinsured children. In addition Kentucky began providing vaccines to underinsured children through the Kids Now tobacco settlement initiative in August of 2000.

KIP participates in the national AFIX program to assist in improving immunization coverage levels among VFC providers in Kentucky. KIP field staff are responsible for conducting annual site visits

to VFC providers to assess immunization coverage levels of children 24 -- 35 months of age and to provide ongoing education regarding methods to increase immunization coverage levels. These methods include reminder and recall systems, immunizing children during sick visits as well as well-child visits. KIP field staff also monitor compliance with vaccine storage and handling requirements to minimize the loss of vaccine.

KIP conducts an annual school survey to assess the coverage levels of children enrolled in daycares, head start programs, preschools, kindergartens and sixth grade. KIP field staff audit a sample of these schools to ensure that the census survey data is accurate. They also provide assistance to schools in assessing children's compliance with immunization requirements. The parents of these children are then contacted and informed of their child's need for immunizations.

Last Year's Accomplishments (2007)

As part of the VFC program, transaction data for 2007 indicates that KIP distributed 611, 000 vaccine doses to public providers and 366, 674 vaccine doses to private providers, for a total of 977, 674 doses, for administration to Kentucky children aged 0 to 18 years of age. Vaccines distributed by KIP cover Diphtheria, Haemophilus Influenzae B, Hepatitis A, Hepatitis B, HPV, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Rotavirus, Rubella and Varicella. Transaction data cannot be extrapolated by age.

The most current NIS data (for 2006) indicates a coverage rate of 84% (CI 5.2) for the 4:3:1:3:3 immunization series of Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenzae B and Hepatitis B for children 19 to 35 months of age. NIS data reflects a sample of children in Kentucky, regardless of their participation in the VFC program, and is a more accurate reflection of coverage than KIP could provide. However, NIS data reflects immunization practices from January 2003 to June of 2005 and does not provide coverage data for all immunizations provided by KIP.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Purchase of vaccines to cover the underinsured, non-Medicaid and non-KCHIP	X		X	
2. Continued financial support for immunizations from the KIDS NOW! Early Childhood Authority			X	X
3. Continued program activity by the Division of Epidemiology and Health Planning Immunization Program			X	X
4. Partnerships with the Dept of Education and Head Start to include immunization as a requirement for enrollment.				X
5. Increased outreach by local health departments for EPSDT/Well Child Preventive health visits	X		X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addition to the annual activities, an additional two million and seventeen thousand dollars ($2,017,000) have been added to the State FY 07-08 biennial budget for vaccination of underinsured children. The cost of vaccines has risen approximately 33% from FY 06-07 to FY 07-08. In addition, the recommended ages for receiving the Meningococcal dose were expanded

in October of 2007. These variables reiterate the fact that the cost to vaccinate a child increases each year.

KIP is currently working on developing a secure and confidential web-based Immunization Registry through a contract with Custom Data Processing (CDP). The Immunization Registry will help to ensure that all persons within the Commonwealth of Kentucky are protected against vaccine-preventable disease. The registry will be used to identify pockets of need, consolidate records for individuals who do not have a medical home or who move, minimize vaccine administration errors and help to measure the effectiveness immunization campaigns.

The Kentucky Immunization Registry Workgroup, which is composed of representatives from local health departments, the Deputy Commissioner for Public Health, Epidemiology and Health Planning Division staff and KIP staff, meets twice a month to review changes and additions to the immunization registry.

c. Plan for the Coming Year
In addition to annual VFC/AFIX activities and school surveys in 2009, the Immunization Registry will be piloted to selected local health departments and private providers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	29	29	21	23	23
Annual Indicator	24.8	23.7	23.9	25.2	24.8
Numerator	2012	1928	1994	2134	2100
Denominator	81198	81291	83328	84846	84846
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	23	22	22	21	21

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change. Teen birth rates have been steadily declining in KY as well as the nation over the last few years. Teen birth rates increased by 2.7% in 2006 in Kentucky as well as the nation. This was the first increase in 15 years nationally.

Future Objectives were reviewed but no changes were made at this time because the 2006 data is preliminary and numbers could change.

Notes - 2005
Teen birth rates have been steadily declining in Kentucky as well as the nation over the last few years.

a. Last Year's Accomplishments
General Program Information - Teen Birth Rate/Family Planning Services

Overall Teen Birth Rates

For 2005 the teen birth rate of females aged 15-17 increased from 23.0 per 1,000 in 2004 to 24.0 per 1,000 in 2005. The Kentucky birth rate increase is consistent with the upward trend in the national birth rates. The national preliminary birth rates for girls aged 15-17 in 2006 is 22 per 1,000, up 3% from a record low of 21.4 in 2005 according to the National Center for Health Statistics.

A full array of reproductive healthcare services for individuals of all ages is available through federal Title X funds allocated to local health departments. Services include client education, counseling, history, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted disease testing and treatment.

119,036 women, men, and adolescents were served through the Title X program in calendar year 2005. Of those served, 19,944 were between the ages 15-19. These services provide primary and preventive health intervention services for adolescents. The services for adolescents that affect this measure include: the School Health and Adolescent Preventive Health Services, Family Planning for Teens, Teen Pregnancy Prevention, Abstinence and Healthy Lifestyle Education.

The Kentucky Family Planning Title X Program has several special initiatives targeted to service disparate populations. Two Hispanic clinics target low income under insured Hispanic clients. Brighton Center Youth Development Program in Newport, Kentucky teaches youth positive youth development skills and refusal skills towards risk taking behaviors. Family Participation Workshops encourage family participation in the decision of minors seeking family planning services. The Pike County Male Special Initiative Project services a local health department clinic, a college based clinic, and an in-school program for middle school males who are taught goal setting and self-esteem skills. Two initiatives focus on teen pregnancy prevention they are the Teen Pregnancy Prevention Intervention Program and the University of Kentucky Young Parents Program (YPP). Both agencies provide intensive counseling to teens to prevent teen pregnancies and repeat teen births and also comprehensive adolescent preventive health care services. YPP is unique because it places emphasis on medical, nursing, and nutritional care for both mother and child, education toward better parenting, career and educational counseling, psychosocial support of the family unit; and family planning services.

Kentucky received $817,297 in FY 2007 in Federal Title V 510 B grant funds for the Abstinence Education Program. In FY 2007, 95 percent of the funding was awarded by the Department for Public Health to 16 local health departments statewide reaching rural and urban areas. The main goal of Kentucky's Abstinence Education Program is to reduce teen out-of-wedlock birth rates and pregnancies. These funded agencies provided abstinence-until-marriage education services using evidence based behavior modification strategies to provide a clear and consistent abstinence-until-marriage message, without contraception and condom use, early and reinforced the message by continuing abstinence interventions throughout the adolescent years. Two major focuses of Kentucky's Abstinence Education Program Grant are positive youth development, through teaching values and practical skills to abstain from sexual activity, and the development of strong partnerships among non-profit public and private community agencies, faith-based organizations, parents, and schools.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued strategic planning with partners			X	X
2. Continued training opportunities through the Title X Family Planning funding support			X	X
3. Continued training opportunities through the Title X Family Planning funding support		X	X	X
4. Partnership coordination with the Coordinated School Health program to encourage schools in positive youth development			X	X
5. University of KY Young Parents Program, Pike Co Male Special Inititative Project and Teen Pregnancy Prevention Intervention Program	X	X	X	
6. Partnership with the Kentucky Teen Pregnancy Coalition			X	X
7. Strategic Planning with partners from AMCHP, HIV and STI Prevention and Adolescent Health.			X	X
8.				
9.				
10.				

b. Current Activities

Kentucky received $5,723,783 in federal Title X funding. Kentucky funds 160 Title X clinics, with the majority of this funding is allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. All Title X delegate agencies must have a sliding fee scale based upon federal poverty guidelines and must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

Family Planning initiatives include two Hispanic clinics; Teen Pregnancy Prevention Intervention Program; Young Parents Program; Brighton Center Youth Development Program; Family Participation Workshops; and the Pike County Male Initiative Project.

KY received $817,297 in federal funding allocated to 16 local health depts. Programs are designed to improve adolescent health outcomes and enhance the positive youth development of KY's youth through school programs (before, during and after), parent education workshops, public awareness events, adult and peer mentoring programs, and community coalitions/partnerships. School and community-based abstinence education curriculum are specifically designed for adolescents aged 10-19. Some programs are taught by peer educators who reinforce the message through positive peer pressure.

c. Plan for the Coming Year

Goals include: To assure access to comprehensive quality family planning services; to provide comprehensive reproductive prevention services; to assist women, teens, and men to prevent unintended pregnancy; teens will delay sexual involvement and the pregnancy rate for teens will be reduced and teens will report less risk taking behaviors as reported in the Youth Risk Behavior Survey.

Women of childbearing age and men will have the information and means to protect themselves from sexually transmitted diseases and STDs will be reduced in this population.

To help meet these goals, the program must continue to market services through community

participation committees and community plans; prepare or recruit additional providers; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas. Collaborations with community/school/health department teen pregnancy prevention initiatives in all 120 counties, while also promoting and conducting Parent Workshops through local health clinic's programs, will assist in promoting teens delaying sexual involvement and ultimately decrease the teen pregnancy rate.

Kentucky's Abstinence Education Program's goals include:

1. Provide evidence-based abstinence-until-marriage education and positive youth development initiatives to youth aged 10-14 years old.
2. Provide evidence-based abstinence-until-marriage education and positive youth development initiatives to youth aged 15-19 years old.
3. Hold one statewide community awareness event in collaboration with the Kentucky Teen Pregnancy Coalition and participate in one community awareness activity.
4. Provide professional development opportunities and trainings to abstinence education staff and educators to increase their competency in providing abstinence education services.
5. Provide training to parents in how to encourage and support their teens in delaying sex until marriage.
6. Develop and implement strategies for postponing sexual activity until marriage and activities targeting youth in high risk populations at the community level.

To meet these goals and the needs of communities, the funded Abstinence Education Program agencies selected research-based abstinence-until-marriage curriculums and other positive youth development approaches which created a sense of ownership and community interest furthering the diffusion of the abstinence-until-marriage message.

The Department for Community Based Services (DCBS) in coordination with other state agencies is piloting an after school project for middle and high school age youth that are at risk of potentially life altering situations, such as premarital parenting, alcohol and substance use, falling behind in school, and entering the foster care or juvenile justice system. The Youth Promise Program partners will work closely in communities to create significant positive effects with high-risk teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	32	35	33	33	30
Annual Indicator	29.0	29.0	29.0	29.0	29.0
Numerator	15478	15222	15222	15222	15222
Denominator	53375	52489	52489	52489	52489
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	31	32	33	34	34

Notes - 2007
The survey was last conducted in 2004. The Oral Health program anticpates conducting the survey next calendar year and will have updated data the following year.

Notes - 2006
The survey was last conducted in 2004. The Oral Health program anticpates conducting the survey next calendar year and will have updated data the following year.

Notes - 2005
2005 data is preliminary and numbers could change.

a. Last Year's Accomplishments
With State General Fund dollars, Kentucky's sealant program funded ($8,000 per site) sealant activities in 23 local health departments. In collaboration with local dental hygienists and dentists as well as community schools, local health departments were provided with funding to purchase portable dental exam equipment. These partners worked together to provide screenings and sealants on Kentucky's 2nd, 3rd and 6th graders throughout the Commonwealth. Parents were informed on the program through informed consent signature forms. In FY 06-07, approximately 13,845 sealants were provided to children.

The University of Kentucky, College of Dentistry participates annually, in cooperation with the Department for Public Health Oral Health Program, in "Seal Kentucky" activities, including traveling with first-year student dentists and faculty to selected rural counties for the application of sealants for children who might not otherwise see a dentist. Scheduled in October, this activity is mutually beneficial for children and residents alike, with many residents noting that this opportunity was one of the highlights of their graduate experience.

Student and staff volunteers from Kentucky's two dental schools, University of Kentucky and the University of Louisville, dental hygienists schools, staff from the Kentucky Oral Health Program and Kentucky Dental Association volunteers provided oral health screenings, sealants, fluoride varnish and education to children at the Kentucky State Fair.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide grants to selected local health departments to purchase dental equipment and fund local level dental provider partnerships for sealants	X		X	
2. On-going support of the Kentucky Children's Oral Health Surveillance System, tracking oral disease and sealant use throughout the Commonwealth.			X	X
3. Continued oral health education at the local level to families, health providers (including nurses and physicians) and the community			X	
4. KIDS SMILE fluoride varnish program through local health departments, which includes the application of fluoride varnish and good oral health care education to the parents and family	X		X	
5. Continued partnership with the University of Kentucky, College of Dentistry and their SEALKENTUCKY program, reaching children statewide and especially in rural, underserved areas	X	X	X	

6. Ongoing strategic planning for children's oral health care in KY			X	X
7. Continued collaboration with the UK Center for Rural Health			X	X
8.				
9.				
10.				

b. Current Activities

On September 1, 2007, the Kentucky Oral Health Program (KOHP) received notification of a four year grant award for $160,000/year funded by the Targeted MCH Oral Health Service Systems (TOHSS) Grant to advance the State oral health program toward sustainability and provide a statewide approach to preventing oral disease. Kentucky's initiative is focusing on ensuring restorative treatment of active disease identified through the Kentucky Sealant Programs (KSP). Two pilot project sites, Kentucky River District Health Department (KRDHD) and the Purchase District Health Department (PDHD) have been selected to provide case management for children identified as needing restorative care through the Kentucky Sealant Program. In addition, outreach efforts and coalition development will be included in these projects.

Additionally, with State General Fund dollars, Kentucky's sealant program funded sealant activities in 23 local health departments. Local health departments and their community partners work together to provide screenings and sealants on Kentucky's 2nd, 3rd and 6th graders throughout the Commonwealth. These programs were inaugurated as school-based program using portable equipment in the school environment. Since the initial implementation of the Kentucky Sealant Program, at least two local health departments have hired a dental hygienist and/or dental assistant to coordinate their programs, provide sealants in schools and be reimbursed by Medicaid or KCHIP.

An attachment is included in this section.

c. Plan for the Coming Year

Each of the 23 state funded sealant programs has individual methods for tracking children receiving sealants through their program; presently there is not a cohesive, statewide tracking system currently in place. Funding from the TOHSS Grant will be used to develop and implement a statewide electronic tracking and reporting system for sealants. In FY 2007-2008, over 13,000 sealants have been placed on children's teeth.

During September 2007, the KOHP health program administrator began the process for establishing needed changes to the CDP sealant tracking and reporting system for local health departments. In October 2007, staff from CDP, KOHP and local health finance and administration met to discuss potential changes to the current sealant tracking and reporting system. During January 2008, statewide billing and coding meetings were held for local health department staff. KOHP staff attended these meetings and provided updates regarding additions of sealant related codes for the tracking and reporting of sealants by local health departments. Local health departments began using the new codes in late January 2008. In March 2008, KOHP and CDP staff met to finalize plans for the sealant tracking and reporting documents health departments could utilize at the local level.

During FY 2008-09, the KOHP State General Fund dollars ($184,000) will be used to fund fifteen sealant programs in local health departments. Funding levels to local health departments are based upon sealant activities in FY06-07 and FY07-08, with funding ranging from $4,000 to $24,000/health department. These local health departments and their community partners will work together to provide screenings and sealants on Kentucky's 2nd, 3rd and 6th graders throughout the Commonwealth.

The uniform electronic tracking and reporting system developed to assist with case management and provide sealant data to the KOHP will be implemented statewide in July 2008. A report of sealant activities will be available to local health departments to assist with case management

activities.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5.9	5.9	5.8	4.6	4.5
Annual Indicator	5.3	6.1	5.0	4.2	2.3
Numerator	41	50	41	35	19
Denominator	771987	826377	823524	824209	824209
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	3	3	3	3	3

Notes - 2007
2007 data is preliminary and numbers could change.
Because 2007 data is preliminary, future objectives for National Performance Measure #10 will not be revised at this time.

Notes - 2006
2006 data is preliminary and numbers could change. A slight decline was observed in this indicator from 2005-2006. KY was successful in passing a Primary Seat Belt Law and the Graduated Driver's License Program during our last legislative session. It is hopeful that with continued prevention and education efforts along with the two new laws, that this indicator will continue to decline.

Future objectives were reviewed but no changes were made at this time because the 2006 data is preliminary and numbers could change.

Notes - 2005
2005 data is preliminary and numbers could change. A slight decline was observed in this indicator from 2004-2005. KY was successful in passing a Primary Seat Belt Law and the Graduated Driver's License Program during our last legislative session. It is hopeful that with continued prevention and education efforts along with the two new laws, that this indicator will continue to decline.

a. Last Year's Accomplishments
The Department for Public Health and the Maternal and Child Health Branch worked through three different avenues to address motor vehicle injury and child related deaths. These efforts included local health department's HANDS programs and primary care programs, state and county SAFE KIDS coalitions and chapters as well as prevention measures identified through the Child Fatality Review Program (CFR). Maternal and Child Health serves as the lead agency for

the state SAFE KIDS coalition and provided technical support for SAFE KIDS chapters around the state. Rural health departments and these SAFE KIDS organizations sponsored car seat check-ups for which they received grant funds that made it possible to purchase seats for low-income families. General Motors and SAFE KIDS sponsor four car seat check-up vans for use around the state. In addition to SAFE KIDS activities, many local health departments had car seat programs that were staffed by certified child passenger safety technicians. Some local health departments were, and continue to be, "fitting stations" where the public may call and make appointments to have their car seat checked by a trained professional. Some of the local technicians are also certified child passenger safety instructors and assist other agencies in training certified child passenger safety technicians. In addition to being "fitting stations", these local health departments partnered with many other agencies such as Drive Smart, Governor's Highway Safety Program, KY State Police, and the KY Transportation Cabinet to hold car seat check-up events within their local communities at car dealerships, day care facilities, retail stores, etc. The HANDS program includes car seat education as part of their home visiting activities. Some health departments also worked with the local judges to provide a diversion program for people cited for not having their child properly restrained or not wearing their seat belts.

The Department for Public Health continued to support injury prevention activities through supporting the development of local injury prevention coalitions and assisting communities in developing local child fatality review teams. There are currently 67 local child fatality review teams. Teams are lead by the local County Coroner and team members are included from local health departments and Department of Community Based Services, Division of Protection and Permancy. Other members may include law enforcement, EMS, school personel, and local County or Commonwealth Attorneys. The Department for Public Health works closely with the Kentucky Coroner's Association and Dr. Ruth Ann Shepherd, Title V Director is a regular featured speaker at the Coroner's Annual Conference. Brian Ritchie, a local coroner is a member of the State CFR team and was active in the advocacy of the Booster Seat Legislation.

The Department also partnered with the Pediatric and Adolescent Injury Prevention Program at the University of Kentucky to support their injury prevention efforts including Core Injury Prevention, Product Safety including lead safe products, and the Violent Death Reporting System.

Kentucky identified three components that would be critical to reducing traffic related deaths to children under age 18. These are: 1) Education; 2) Product modification, such as improved safety features in automobiles; and 3) Legislation. Of these three, legislation was identified as being the most useful in reducing childhood injuries and death. Many bills were introduced to accomplish this goal and three were passed into law. The ATV helmet usage law, graduated driver's licensing law and primary seatbelt usage law were all passed and will affect a positive change on the amount of children hurt or killed in motor vehicle crashes in Kentucky.

The Commissioner for the Department for Public Health served on the KY Youth Development Coordinating Council which worked to develop a strategic plan for KY's youth, ages 8-21. One component they addressed was that kids have a healthy start and future. They also addressed safe places and structured activities which could also make a great deal of difference in the lives of children in Kentucky.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Collaboration with other CDC grants including the Core Injury Prevention grant and the KY Violent Death Reporting Systems grant. Both grants are administered by the Dept for Public Health and include multiple partners and collaborations.			X	X
2. Enhancement of the Child Fatality Review process to increase the development and participation of local CFR teams			X	X
3. Injury prevention training included in the HANDS Home Visitation curriculm			X	X
4. Collaboration with the Kentucky Injury Prevention Research Center at the University of Kentucky			X	X
5. Participate in the Governor's Drive Smart Team that includes safety seat checkups and other safe driving inititatives			X	X
6. Collaboration with Coordinated School Health to provide safety information brochures			X	X
7. Legislation for a Booster Seat law, a Primary Seatbelt law, ATV helmet requirement for persons under age 16 and Graduated Driver's license that includes training for teens			X	X
8. Continuation of the Kentucky Safe Kids Coalition and local Safe Kids chapters			X	X
9. Publication of the Child Fatality Review annual report			X	X
10. Ongoing strategic planning for children's safety and injury prevention in KY			X	X

b. Current Activities

The CFR Annual Report consists of data about child deaths and offers recommendations to the Governor. Fatality review/injury prevention programs target children 0-18 to reduce child death/life threatening injuries. Most counties participate in injury/death prevention education. 67% of KY counties have fatality review teams that partner with local coroners, Child Protection, law enforcement, and others to prevent child deaths/injuries. Most counties offer grief counseling. In 2008, the KY General Assembly passed child booster seat legislation for children under age 7 and between 40 and 50 inches.

Education is provided to parents, daycares and schools about the primary seat belt and graduated driver's licensing laws. Included in this education are court diversion programs. Several counties offer these as an option for those ticketed for not wearing seat belts/not having their child properly restrained. They pay a reduced fee and receive education on safety seat installation/importance of seat belt use. These funds buy car seats that are offered at a reduced price or provided free for families who cannot afford them. SAFE KIDS, Governor's Highway Safety Program, Drive Smart, local health departments, state police, Kentucky Pediatric Society, and others will use Child Passenger Safety Week to provide education on the importance of this issue. Fayette Co is working with middle schools to encourage teen seat belt useage. Efforts continue to train child passenger safety technicians.
An attachment is included in this section.

c. Plan for the Coming Year

Many of this year's activities will be ongoing throughout the next year. KY is working to increase the number of counties that have child fatality review teams by providing technical assistance and training to encourage this vital collaboration among agencies.

DPH has identified several target areas from the Healthy 2010 objectives for health departments to choose as areas to work on in the coming year including motor vehicle and passenger safety. Public education will continue to be vital to any issue addressed at the local level. Safety seat use, restraint/seat belt use, helmet use, graduated driver licensing, and legislation promotion are

the areas that will be addressed in 2009. Ninety percent of Kentucky local health departments will address at least one of these areas. In addition to local health departments, some counties have applied to SAFE KIDS for money that will be used to provide car seat check up events, public education and other behavior changing activities in their communities. These counties are Bell, Madison, Estill, Christian, Hardin, and Metcalfe. Barren County functions as its own coalition and will continue extra activities as well.

ATV safety continues to be a growing problem for children in Kentucky. The Department for Agriculture has created a two-day education program that allows staff to travel around the state and educate children in rural Kentucky counties about ATV safety. They do mock crashes and simulate an ATV rescue. This program is in high demand and will continue to try to meet as many requests as they can. Knott County has also leveraged local coal funds to build an ATV training course that will open in 2008. This course will be used to educate children in Eastern Kentucky on the correct operation of ATVs. Their local child fatality review team has also joined together to collect $1500.00 to be used to buy helmets to give away at their training course.

Drive Smart, Kentucky Governor's Highway Traffic Safety Program, Kentucky Pediatric Society, local health departments, SAFE KIDS, and others will continue to work together to do check-up events, provide education to parents, teachers, children, teens, and others as to the importance of child passenger safety and seatbelt usage. Child Passenger Safety Week will be a focus of intense activities to enhance this safety message. The HANDS program will continue to reinforce the importance of child passenger safety to first time parents. Counties will continue the court diversion programs to provide education to people ticketed for not adhering to seat belt laws. Money collected in the programs will be used to purchase car seats that can be offered free or at a reduced rate.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				25	26
Annual Indicator			25.3	27.5	27.5
Numerator			13915	3980	3980
Denominator			55000	14465	14465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	28	28	30	30	32

Notes - 2007
Data reflects 2006 data. The 2007 data is not yet available.

Notes - 2006
Data for 2005 was incorrectly calculated and should be 7080/27987.

Notes - 2005

Data provided is from the KY WIC program and numbers reflect only those mothers who receive WIC.

a. Last Year's Accomplishments

In Kentucky, 26.4% of mothers breastfed their infants until 6 months of age as compared to the national rate of 41.5% according to the CDC National Immunization Survey, 2004. The Healthy People 2010 goal for duration is to "Increase breastfeeding at 6 months of age to 50%". The Pediatric Nutrition Surveillance (PedNSS) 6 month duration rate for 2005 was 4.8% as compared to the national rate of 23.4%. In 2006, the rate had increased to 27.5% for Kentucky and nationally to 24.3%. This increased rate for Kentucky is related to improved data reporting and not a true increase in duration.

Initiation rates for breastfeeding for 2004 from the CDC Breastfeeding National Immunization Data Report show a rate of 49.6% for Kentucky as compared to the national rate of 41.5%. The Kentucky Birth Certificate data for 2005 indicates an initiation rate of 52.65% as compared to the national rate of 50.8%. Collection of breastfeeding data has always been a difficult task due to collection methods (e.g., one time surveys, point in time data report, etc.) and accuracy of comparing different reporting sources (e.g., CDC Immunization Report, Mothers Survey, PedNSS, etc.).

Accomplishments 2007

• Was signed into law March 2007 a legislative bill - "Act relating to Jury Duty".
• Developed and distributed 8 new breastfeeding pamphlets.
• Translated breastfeeding pamphlets into Spanish.
• Continued funding for 10 Regional Breastfeeding Coordinators.
• Continued 8 Breastfeeding Peer Counselor Programs and provided training and technical assistance as needed.
• Began a Statewide Breastfeeding Coalition and held meetings in conjunction with the CDC Bi-Monthly Conference call.
• Celebrated World Breastfeeding Week and Breastfeeding Month in KY.
• Sponsored a Breastfeeding Conference June 6, 2007 and had 175 attendees.
• Updated and revised the Breastfeeding Report (1596 report) to improve data collection from WIC clinics.
• Continued to serve on the March of Dimes Committee to provide breastfeeding focus.
• Provided opportunities for staff members to work toward requirements for IBCLC certification.
• Continued to provide single-user electric breast pumps for moms returning to school or work.
• Provided rental of hospital grade breast pumps for mom and babies who are separated due to medical need.
• Continued to provide training and technical assistance to local agencies.
• Provided training to hospitals and community partners on breastfeeding support and promotion.
• Developed worksite breastfeeding packet as part of the Worksite Wellness Tool Kit.
• Ordered new DVD with a focus on Prematurity for training local agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training and support of WIC Breasetfeeding grantees for breastfeeding promotion in local communities	X		X	X
2. Breastfeeding Coalition building			X	X
3. Training provided to local hospitals and community supporters/partners			X	X
4. Promotion and training of the health benefits of breastfeeding in the HANDS Home Visitation curriculm	X		X	X

5. Legislation that supports breastfeeding in local communities			X	X
6. Participation in world and national breastfeeding promotion campaigns			X	X
7. Continued collaboration with Fit KY, Regional Breastfeeding Coordinators and Shape the Future Steering Committee			X	X
8. Collaboration with CDC Nutrition, Physical Activity and Obesity Grant			X	X
9.				
10.				

b. Current Activities

• Increase breastfeeding initiation and duration rates through continued education, promotion and support efforts.
• Continue to work with 9 breastfeeding coalitions across the state.
• Plan activities for World Breastfeeding Week August 2008.
• Continue funding for 10 Breastfeeding Grantees.
• Continue to provide training and education to the Breastfeeding Peer Counselor sites.
• Translate new breastfeeding materials into Spanish.
• Promote and educate the health care provider and the general public on Senate Bill 106 "An Act Relating to Breastfeeding". This legislation has been printed on business cards to alert the public of the new breastfeeding bill.
• Promote and educate on Breastfeeding Bill SB 111 - An act excusing breastfeeding moms from jury duty.
• Develop new ideas to promote breastfeeding in Kentucky.
• Develop a Breastfeeding Needs Assessment.
• Continue collaboration with the CDC Nutrition, Physical Activity and Obesity grant, University of KY and other public and private partners.
• Continue to have state Breastfeeding staff member work to become an IBCLC. The staff member was the first person admitted into University of KY Breastfeeding Internship Program.
• Provide 40 hour training for future IBCLC's.
• Develop breastfeeding displays on Breastfeeding Helps Fight Obesity and Breastfeeding and the Worksite.
• Continue to promote the Baby Friendly Hospital Initiative.
• Plan a Breastfeeding Summit, Fall 2008.
• Maintain the Breastfeeding Peer Counselor Program.

An attachment is included in this section.

c. Plan for the Coming Year

• Maintain the Breastfeeding Peer Counselor Program and increase participation in the existing sites. Expand to 6 new sites.
• Celebrate Earth Day focusing on breastfeeding.
• Work with USDA to plan the NWA Conference to be held in KY, fall of 2008.
• Provide training for worksites to establish a breastfeeding room.
• Increase breastfeeding initiation and duration rates through continued education, promotion and support.
• Increase participation in the statewide breastfeeding coalition.
• Celebrate World Breastfeeding Week - August 2009
• Continue funding for 10 Breastfeeding Regional Coordinators
• Continue to offer Breastfeeding continuing education programs.
• Increase the number of hospitals trained on breastfeeding promotion and support.
• Continue to offer hospital grade breast pumps and single user breast pump to WIC mothers.
• Continue to work to promote the Baby Friendly Hospital Initiative.
• Implement new training modules on breastfeeding promotion, breastfeeding education and three-step counseling.
• Continue to promote and implement Breastfeeding Worksite Toolkit.

• Continue to promote and support breastfeeding through participation in health fairs and conferences with breastfeeding displays.
• Maintain the Breastfeeding Peer Counselor Program in 14 sites and increase the number of sites if funding is available.
• Continue training for worksites to establish a breastfeeding room.
• Continue collaboration with the CDC Nutrition, Physical Activity and Obesity grant, University of Kentucky and other public and private partners.
• Distribute Breastfeeding Needs Assessment and analyze information.
• Continue to promote and educate about the KY breastfeeding legislation.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	98	99	99	99	99
Annual Indicator	99.3	99.4	99.8	99.8	97.8
Numerator	50643	51849	51837	51837	54781
Denominator	51008	52172	51932	51932	55990
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments
As a result of a recently completed Building Community Capacity grant numerous rural communities have a better understanding of why newborn hearing screening is so important and are better prepared to advocate on behalf of children. Interaction among hearing specialists, hospitals and families has nurtured a collaborative spirit within smaller communities in rural Kentucky. Developing a self-sustaining infrastructure has significantly improved access to diagnostic screening.

53,075 hearing screen report forms have been submitted to UNHS. Of the infants screened, 6,044 were at-risk for hearing loss. Of the infants at-risk for hearing loss, 2,328 referred on the newborn hearing screen on one or both ears. The remaining 3,716 passed the screening test, but have a risk indicator that put them in a higher risk category for developing later onset or progressive hearing loss, or for one reason or another were not screened prior to hospital discharge. All 6,044 at-risk infants have been entered in a database and referred for follow-up, which includes dissemination of information to families and assigning a regional coordinator to each child

49 children reported to UNHS with identified permanent childhood hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCSHCN continues to receive results of hearing screens performed in hospitals.	X		X	
2. CCSHCN staff follow up with families when results of hearing screen was not completed, results were not positive, or when there were risk indicators.	X		X	
3. EHDI data is captured, analyzed and reported using the Commission's information system, CUP.			X	X
4. EHDI staff manages the accuracy of submission of the electronic Hearing Screen Reports.			X	X
5. EHDI staff provides outreach and training to stakeholders	X		X	
6. EHDI staff disseminate information to families, physicians and other health care providers.	X		X	X
7.				
8. EHDI staff document follow-up diagnostics.				X
9. EHDI staff report aggregate data to state, regional and federal partners/stakeholders.			X	X
10.				

b. Current Activities

54,781 hearing screen report forms have been submitted to EHDI for FY 2007. Of the infants screened, 7,492 were at-risk for hearing loss. Of the infants at-risk for hearing loss, 2,400 referred on the newborn hearing screen on one or both ears. The remaining 5,092 passed the screening test, but have a risk indicator that put them in a higher risk category for developing later onset or progressive hearing loss, or for one reason or another were not screened prior to hospital discharge. All 7,492 at-risk infants were either entered by EHDI personnel, or entered by hospital personnel and submitted electronically via KY-CHILD, which was implemented in October 2006. All infants that were entered in the database were referred for follow-up, which includes dissemination of information to families and assigning a regional coordinator to each child.

Forty-five (45) children reported to EHDI with identified permanent childhood hearing loss.

c. Plan for the Coming Year

The Commission has been awarded a new MCHB-HRSA grant that will focus on reducing the loss to documented follow-up after failing to pass a universal newborn screening. Kentucky's early intervention program, First Steps, partnered with the Commission. Goals for this grant include:

1) improving the link from the hospital to the 2nd diagnostician,
2) improving communication with the medical home, and
3) improving script to ensure all parties get the same information.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6	6	6	7.5	8.5
Annual Indicator	8.1	9	6.7	9.7	9.7
Numerator	85000				
Denominator	1048000				

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	9	8	7.5	7.5

Notes - 2007
2007 data not available yet, so 2006 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2006
Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2005
Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

a. Last Year's Accomplishments
All uninsured children under age 19 in families with incomes below 200% of the Federal Poverty Guidelines are now eligible for health insurance coverage either through KCHIP or Medicaid. Eligibility is determined by the Department for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid.

Jefferson County (Louisville) and the seven surrounding counties are where KCHIP services for children are covered through the Passport Health Plan. Children residing in the other 112 counties are served through KenPAC, a Primary Care Case Management (PCCM) program.

KCHIP members enrolled in either Passport or KenPAC are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

The Division of Maternal & Child Health Improvement has hired an full time RN and through partnership with the Department for Medicaid Services has been working with local health departments to provide outreach, education and referral for the Kentucky Children's Health Insurance Program.

The Department for Medicaid services administers statewide EPSDT and KCHIP Outreach through contracts established with the Department for Public Health. During 2008, the Department for Public Health reinforced EPSDT Outreach through development of outreach goals and objectives, workshops and training for health department providers, and improvement of reports and feedback used by health departments for implementation of verbal notification of eligible Medicaid children. To assure a resource for information about KCHIP enrollment and referral to health care providers, the Department for Public Health allocates funds to two health departments in Lexington and Louisville to administer the statewide KCHIP outreach hotline, providing touchtone dialing and translation services.

Between 2002-2005, a grant from the Robert Wood Johnson Foundation supported the Covering

KY Kids and Families Coalition outreach initiative to focus on coordinated statewide outreach, policy development, application assistance and facilitation of interviews for Medicaid and SCHIP eligibility determination. Although unfunded in 2008, the Kentucky Covering Kids and Families Coalition met monthly from October through February with state agency and private health care partners to advocate support for the reauthorization of KCHIP, improved funding measures for outreach and services and development of strategies to simplify enrollment and retention of eligible children.

Additional efforts were initiated in 2008 to assure coverage for eligible children, although Title V funds are available to cover expenditures for services provided by Kentucky health departments for children who are not covered or eligible for Medicaid:

In Jefferson County and 15 Kentucky counties, Passport Health Plan assures services for children who are eligible for Medicaid or KCHIP coverage. During 2008, MedAssist implemented the Jefferson County pilot Medicaid enrollment and retention project, funded by a grant from the Anthem Foundation and administered through Passport HMO, to identify and provide follow-up enrollment services to potentially eligible children based on a comparison of free and reduced-price meal program enrollment with Medicaid and KCHIP enrollment.

Citizens of Louisville Organized and United Together (CLOUT), a community based organization in Louisville composed of diverse faith-based civic and neighborhood groups within low to moderate-income communities of Louisville and Jefferson County, promoted grassroots community action and social justice advocacy activities to increase enrollment of eligible children in KCHIP.

The Well Child/Pediatric and Adolescent Preventive Health Care Program is coordinated by the Division of Maternal and Child Health through local health departments statewide. The purpose of the program is to provide Comprehensive Health and History Screening and assessment of the physical, mental, and social well being of children birth through 20 years of age regardless of the ability to pay. Referrals are made to specialists when needed. Local Health Departments provide outreach and education to families on the importance of preventive health screening

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued support for Medicaid/KCHIP enrollment and services through local health departments and the Commission for Children with Special Health Care needs.			X	X
2. Collaboration with Medicaid to access needed data for MCH programs.			X	X
3. Collaboration with Medicaid/KCHIP program initiatives			X	X
4. Collaboration with EPSDT Outreach through local health departments	X		X	
5. Collaboration with Local Health Department Well Child programs	X		X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2007 saw the approval and implementation of Governor Fletcher's Medicaid Modernization initiative, including development of the recently-approved KYHealth Choices program designed to

help control growing costs in the Medicaid program while improving the quality of care for its 700,000 members.

The Kentucky Department for Medicaid Services introduced the KYHealth-Net system (formerly known as the Internet Information Processing System) that allows providers instant access to recipient information. This system is currently available to Actively Enrolled Kentucky Medicaid Providers only and includes a user manual with details of what is available on-line as well as step-by-step instructions on how to use the KYHealth-Net system. Information on Recipients, KenPAC, Nursing Facilities, Medical Claim Status, Pharmacy History, Qualifying Income Trust (QIT), Regional Transportation Broker Listing, Service Limitations, Remittance Advices and Check Amounts are included on the system.

KY allocates the majority of Title V funding to local health departments to provide clinical and community health education in all 120 counties. These services include Well Child/Pediatric and Adolescent Preventive Health Care, Oral Health and Nutrition, etc. Additional efforts were initiated in 2008 to assure coverage for eligible children, although Title V funds are available to cover expenditures for services provided by Kentucky health departments for children who are not covered or eligible for Medicaid.

c. Plan for the Coming Year

The Department of Medicaid Services, Division of Child's Health Insurance promotes responsible partnerships between families and community agencies to establish and maintain access to health insurance for Kentucky's children and is responsible for the program development and reimbursement functions of the Title XXI Kentucky Children's Health Insurance Program (KCHIP). It serves as the liaison between the public, professionals, and Department of Public Health staff on relevant issues. This Division is responsible for policy recommendations, program development, and provider communications for the SCHIP program. The Division is also responsible for monitoring member enrollment and service expenditures to ensure the program stays within budget. It is also responsible for monitoring participating providers for compliance with state and federal regulations and their achievement of service access and quality targets and goals, and providing necessary program technical assistance and training to participating providers. The Division holds quarterly meetings with the KCHIP Advisory Council. The Advisory Council provides valuable input that assists the Division with decisions pertaining to future program development. Members of the Advisory Council are appointed by the Governor.

The KY Department of Public Health allocates the majority of Title V funding to local health departments that provide clinical and community health education in all 120 counties. Clinical and preventive health services are provided on a sliding fee scale when Medicaid or other payment sources are unavailable.

Medicaid Modernization initiative, KYHealth Choices, is a program designed to help control growing costs in the Medicaid program while improving the quality of care for its members. No services were eliminated or altered for children or pregnant women under the KYHealth Choices.

A shared vision for the betterment of all Kentucky exists within the team of Governor Steve Beshear and Lt. Governor Daniel Mongiardo. Achieving sustainable economic growth, lifelong learning opportunities -- beginning with pre-kindergarten -- and affordable health care, especially for children, have been identified as matters of utmost priority.

Leading the health care initiatives is Lt. Governor Daniel Mongiardo. Lt. Governor Mongiardo has dedicated his career as a physician and surgeon in Eastern Kentucky and his record as a Kentucky State Senator to the areas of health care and family services. As a senator, he emerged as a strong advocate of bold and innovative health care proposals.

The Division of Maternal and Child Health Improvement has hired an full time RN and through a

partnership with the Dept for Medicaid Services has been working with local health departments to provide outreach, education and referral for the Kentucky Children's Health Insurance Program. She has been working with local health department staff to expand EPSDT Outreach including training, site visits and technical assistance.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				32	34
Annual Indicator			35.3	17.9	16.4
Numerator			45948	9626	9367
Denominator			130165	53777	57117
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16	16	15	15	15

Notes - 2007
Data is from the PedNESS survey.

Notes - 2006
Data is from 2006 PedNSS survey of WIC providers in Kentucky. Data for 2005 should be 18.2% (10,051/55227), but cannot be changed on the form. Data from 2006 is also from KY PedNSS.

a. Last Year's Accomplishments
Priority: Reduce obesity among Kentucky's children.

Obesity remains a problem in Kentucky, despite significant progress in community efforts all across the state. Around 30% of WIC children ages 2-5 are already overweight (BMI>85%tile). The WIC program has automated electronic growth charts for children served and is the only state program regularly measuring BMI's on children to identify and address their nutritional needs.

The WIC Program implemented an web based automated growth chart program which automatically plots and calculates BMI for any person under the age of 20 who receives weights and measures in the health department. This Program was implemented statewide in the summer of 2006 resulting in a decrease to the errors in plotting weights and measures and calculating BMIs.

In 2006, final data from Pediatric Nutrition Surveillance System (PedNSS) reports an increased percentage of children with inappropriate weight for height. The breakdown includes the following:

Growth Parameter	PedNSS 2006	PedNSS 2005
Underweight (<5%)	5.3%	4.5%
Short Stature	7.0%	7.5%

Overweight	17.4 %	18.1 %

In 2006, there are an additional 17.9% of children age 2-5 that fall into the category of At Risk for Overweight as compared to 18.2% in 2005.

Data Issues

Current data from the Pediatric Nutrition Surveillance System (PedNSS) only reflects data on children under the age of 5 seen for WIC services. During late 2006, implemented automated growth chart system that was to be used with all health department services for children under the age of 21. This system is now statewide and data over the next years should reflect children seen for other health department services. The 2007 data from PedNSS will begin to provide data on children seen in the health department for Well Child/EPSDT and will capture children up to the age of 21. Future plans include providing these automated growth charts to private providers and collecting data from participating physicians across the state. This will begin to assist the state in analyzing the true statewide problem of inappropriate growth.

Provided funding for a network of Registered Dietitians/Certified Nutritionists to provide Medical Nutrition Therapy in 120 counties.
Provided funding for community and school nutrition activities in all 56 agencies
Provided wellness and nutrition activities in 6 health fairs for employees

Provided nutrition information to 15,000 participants over the 10-day Kentucky State Fair
Printed 10 new/revised nutrition materials for local health departments to use with clients
Completed the first year of nutrition monitoring for quality assurance in 20% of agencies.
Provided internship experience for 4 nutrition students
Continued participation in WIC Farmers' Market Nutrition Program
Continued to be a liaison to the following committees/coalitions:
o Kentucky Action for Healthy Kids
o Partnership for a Fit Kentucky
o Kentucky Diabetes Network
o Folic Acid/Prematurity Partnership
o School Health Coalition
o AHEC Health Careers Outreach
o Kentucky Food Security Partnership

Kentucky's WIC Program is available in all 120 counties. The WIC Program provides counseling to all children and women concerning healthy foods and the importance of regular physical activity. The current caseload for WIC is approximately 135,000 participants.

Through the Nutrition and Physical Activity Initiative, Kentucky has developed 16 regional coalitions that are address specific local activities to meet the 6 CDC identified strategies (breastfeeding, decrease screen time, increase physical activity, dietary quality, parental involvement and increased fruit and vegetable consumption). Each region must develop a community plan that addresses nutrition and physical activity with the goal of impacting escalating obesity rates.

Partnership for a Fit Kentucky is a state-wide coalition which was organized by the Nutrition Branch to implement the CDC grant for the Obesity, Nutrition, and Physical Activity Program. This program developed the burden document "Kentucky's Obesity Epidemic" in 2004, and let partners in the development of the Kentucky Nutrition and Physical Activity State Action Plan" in 2005 that is now in implementation phase. Local input was obtained from 9 regional forums, and resulted in the development of 11 regional coalitions to work on nutrition, physical activity, and obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Physical Activities promoted through local health departments	X		X	X
2. Nutritional counseling to families available through local health departments.	X		X	X
3. Collaboration between local health departments and schools to promote physical activity and nutrition.		X	X	X
4. Physical Activity Conference				X
5. HANDS Home Visitation services	X	X	X	X
6. Well Child and Adolescent Preventive Health and Nutrition services training for local health department staff				X
7. Automated BMI and Growth Charts	X	X	X	X
8. Increased educational materials and counseling for families	X	X	X	X
9. WIC Farmer's Market Nutrition Program	X	X	X	X
10. Continued collaboration and strategic planning with multiple partners			X	X

b. Current Activities

• Finalize timeline for VENA training and implementation.
• Implementation of Revision 8 and 9 for WIC Nutrition Risk.
• Continue to refine automated risk and growth charts to work with VENA.
• Continue funding for dietitian/nutritionist network.
• Continue revision of nutrition materials.
• Continue to provide nutrition information and displays at the State Fair.
• Development of new display concerning Fast Food Facts and the importance of fruits and vegetables.
• Continue quality assurance monitoring.
• Continue to have staff serve as liaison to:
o Partnership for a Fit KY
o Folic Acid and Prematurity Partnership
o Arthritis Partnership
o KY Diabetes Network
o Kentuckiana Lactation Improvement Coalition
o Western KY Breastfeeding Coalition
o Coordinated School Health Coalition
o AHEC
o March of Dimes
o EBT
o KY Food Security Partnership
• Continue to provide nutrition focus in employee wellness health fair.
• Implement new food packages for WIC.
• Develop and provide training on new food packages.
• Create new materials for local staff to assist in the provision of nutrition education and the new food packages.
• Management of WIC FMNP has been assumed by the Nutrition Services Branch and Clinical Nutrition Section.
• Provide training and technical assistance for WIC FMNP.
• Develop new online modules with KCTCS for educating local staff on relevant WIC topics.
• Provide continuing education training on eating disorders.
• Continue training and technical assistance for local agencies.

c. Plan for the Coming Year

• Host the National WIC Association Nutrition and Breastfeeding Conference September 23-25 in Louisville.
• Develop new fruit and vegetable logo and provide training.
• Conduct focus groups to evaluate new materials for VENA.
• Implement VENA training -- new nutrition assessment and provision of nutrition education.
• Pilot test new education modules for WIC and VENA.
• Continue WIC Farmers' Market Nutrition Program and provide training, technical assistance and monitoring.
• Continue quality assurance monitoring.
• Continue training and technical assistance as needed.
• Continue funding for dietitian/nutritionist network.
• Continue as preceptor site.
• Continue nutrition training and technical assistance as needed.
• Implement new web-based system for WIC.
• Continue to revise nutrition materials as needed.
• Provide more education materials for Medical Nutrition Therapy.
• Implement new fruit and vegetable promotion program.
• Continue to have staff serve as liaisons to:
o Partnership for a Fit Kentucky
o Folic Acid and Prematurity Partnership
o Arthritis Partnership
o KY Diabetes Network
o Kentuckiana Lactation Improvement Coalition
o Western KY Breastfeeding Coalition
o Coordinated School Health Coalition
o AHEC
o March of Dimes
o KY Food Security Partnership
• Continue to provide nutrition focus in employee wellness health fair.
• Continue to provide nutrition information and man displays at the State Fair.

Parents and/or caregivers are given information regarding a child's BMI and counseling is provided regarding nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				22	22
Annual Indicator			23.4	24.0	23.0
Numerator			12285	13092	12633
Denominator			52545	54614	54821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	21	20	19	18	18

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
KY 2010 Goal: Increase to at least 20% the proportion of pregnant smokers who abstain from tobacco use beginning in the first trimester of pregnancy and maintain abstinence for the remainder of their pregnancy.

The Tobacco Program's mission is to reduce the amount of disease and the number of deaths related to the use of tobacco among Kentuckians. Initiatives are based on the CDC Best Practices for tobacco control: preventing youth initiation, promoting quitting among adults and young people, eliminating exposure to secondhand smoke, and identifying and eliminating disparities among population groups disproportionately affected by tobacco use. Additional opportunities for CDC grants include projects such as Kentucky's proactive quit line and Tobacco-Free Sports.

Among all women 18-44 in Kentucky, around 29.7 % (2004) are smokers with a National Median of 22.8 % in 2004, while overall 23.9 % of Kentucky's pregnant women are smoking during pregnancy, so there is some impact of the message not to smoke during pregnancy.

Data on activities to decrease smoking prevalence in women of childbearing age:
1. LHD Smoking Cessation Survey
In 2007, 100% of health departments provided programs to help tobacco users quit.
2. Workplace Policy Survey, 2006
Over three-fourths (82.3%) had a written smoking policy, but only 49.3% banned smoking inside the company
More than half (57.4%) provided resources to employees who want to quit using tobacco
3. Behavior Risk Factor Surveillance System, 2006
There was no significant change in adult current smoking in 2006.
4. Birth Records (Vital Statistics)
Kentucky has the second highest rate of women who smoke during pregnancy, 23.9 %, compared to the national average of 10.7 %. Only West Virginia has a higher rate. Our lowest rate by county was 11.7 %, still above the national average. Our highest rate for a county was 45.8 %. Rate of smoking in pregnancy has not changed significantly over the last 10 years.

Activities in Health Departments:
Patients/clients who are seen in any of these programs were screened to identify those using tobacco: Prenatal; Family Planning; HANDS; WIC; Nutrition; Adult preventative care; Pediatric Preventative care (Well Child); and Cancer. Every LHD continues to offer smoking cessation programs/classes, that are available to anyone referred by self or from doctor's offices or other community agencies.

Collaboration with Medicaid:
Legislation passed for Medicaid to cover counseling and pharmacotherapy, however, this has not been implemented due to funding.

Free nicotine replacement therapy was provided for Medicaid recipients who were actively enrolled in counseling with Kentucky's Tobacco Quit Line. The Pilot was a joint project between Medicaid, Public Health and the Tobacco Program. Project period is March 1-December 31, 2007. Preliminary data show a 66.84% quit rate at one month. Evaluation will include quit rates for 3 months, 6 months, and 1 year. The optimal time to get women to quit smoking is before they get pregnant.

Kentucky's Tobacco Quit Line 1-800 QUIT NOW. The Kentucky Tobacco Quit Line is an evidence-based tobacco treatment program and wonderful resource for the Commonwealth. The Quit Line offers individualized cessation counseling for all tobacco users, including spit and chew tobacco, and a specialized protocol for pregnant women who smoke. English and Spanish language counselors are available. A TDY/TDD toll free number is available for individuals who are deaf and hard of hearing: (800) 969-1393. The Quit Line also provides referral information to connect callers with people in their community who can help, such as local and district health departments. Few providers realize the QUIT line is trained to counsel pregnant smokers.

Collaboration with physicians:
Provided Treating Tobacco Use and Dependence and Treating Tobacco Use and Dependence during Pregnancy self-study kits to Kentucky physicians, dentists, nurse practitioners/midwives, physician assistants, dental hygienists and psychologists upon request.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. GIFTS Pilot project that targets pregnant smokers.	X	X	X	X
2. Tobacco Control Coordinators located in local health departments	X		X	X
3. Kentucky's Tobacco Quit line, 1-800-QUIT NOW 30 Quit Line billboards posted across Kentucky	X		X	X
4. Quit Line promotional toolkit developed and provided to local health departments, hospitals, businesses, Kentucky Cancer Program (UK and UL), Cancer information Service		X	X	X
5. Quit Line PSA's developed and distributed to local health departments		X	X	X
6. Local health departments offer Cooper Clayton Method to Stop Smoking. 12 week, cessation program at no cost to participants	X		X	X
7. Nicotine replacement therapy provided to Medicaid eligible pregnant women	X		X	X
8. Partnership with KMA to assist physicians in counseling patients to quit smoking.	X	X	X	X
9. Training for local health department staff in Make yours a Fresh Start Family and health departments providing Make Yours A Fresh Start Family counseling and services	X	X	X	X
10.				

b. Current Activities
DPH received a grant from the Anthem Foundation to reduce smoking in pregnancy in 9 rural counties in rural Eastern Kentucky, whose smoking in pregnancy rates range from 36.2% to 58.3%. The G.I.F.T.S. Program (Giving Infants and Families Tobacco-free Starts) was implemented in February 2008. All pregnant women receiving any service in the LHD in these 9 counties will be screened for tobacco use utilizing the 5 A's approach and they will also be screened for secondhand smoke exposure.

The Program and MCH are partnering with Kentucky Chapter of ACOG (American College of Obstetricians and Gynecologists) to work on improving systems of addressing smoking cessation in the office setting. There are currently three practices piloting the project, which we call ACOG-GIFTS (A Committed Office Giving Infants and Families Tobacco-free Starts).

DPH received a Tobacco Prevention Among Women of Reproductive Age Mini-Grant from the Association of Maternal & Child Health Programs. The Kentucky team will include representatives from MCH, ACOG, Planned Parenthood, and the Tobacco Prevention & Cessation Program. This project will focus on training staff and providers of Planned Parenthood and private obstetrical offices on the 5 A's and the Kentucky Tobacco Quit Line. Based upon evaluation and available funds, this may be a model for statewide intervention.

GIFTS Attachment
An attachment is included in this section.

c. Plan for the Coming Year
Kentucky's plan for the coming year to reduce smoking prevalence includes:
1) Complete hospital in-patient treatment pilot; write case studies; develop toolkit based on pilot.
2) Continue to build on the youth advocacy network
3) Promote Kentucky's Tobacco Quit Line and fax referral system;
4) Update and distribute burden document.
5) Provide training and conference opportunities for grantees and partners;
6) Identify additional funding sources and partners to support program needs;
7) Implement Tobacco Cessation Treatment Specialist Certification program in health departments;

The Department for Public Health (DPH) anticipates continuing implementation of the G.I.F.T.S. Program through the fiscal year 09. DPH received a grant from the Anthem Foundation to reduce smoking in pregnancy in nine rural counties in Eastern Kentucky, whose smoking in pregnancy rates range from 36.2% to 58.3%. The G.I.F.T.S. Program (Giving Infants and Families Tobacco-free Starts) was implemented in February 2008. All pregnant women receiving any service in the LHD clinic in these nine counties will be screened for tobacco use utilizing the 5 A's approach and they will also be screened for secondhand smoke exposure. All pregnant women who are currently smoking or have quit in the past 3 months will be referred for case management and can be followed through pregnancy and up to 3 months postpartum. Case management will include individualized face-to-face contacts as well as screening/referrals for depression, domestic violence and social support. These women will be referred to the KY Tobacco Quit Line and will be provided with educational materials and resources.

Evaluation of results of AMCHP grant efforts

For the next project, The Department for Public Health anticipates partnering with the KY Chapter of the American Academy of Pediatrics to implement a Prenatal Tobacco Cessation Project for their providers.

Implement the Physician Champions program in conjunction with the KMA Committee on Community and Rural Health.

An attachment is included in this section.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective	8.3	8	7.9	7	7
Annual Indicator	6.8	10.0	7.9	9.6	8.5
Numerator	19	29	22	27	24
Denominator	280816	289004	278234	280804	280804
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8	8	7.5	7.5	7

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.

Future objective were reviewed but were not changed because 2006 data is preliminary and number could change.

Notes - 2005
2005 data is preliminary and numbers could change.

a. Last Year's Accomplishments
The Kentucky Suicide Prevention Group (KSPG) had ten full group meetings with varying standing committees and as needed subcommittees meeting intermittently regarding assigned projects. KSPG has been in existence since 2002 and focuses on suicide prevention strategies for all age groups. Their goals continue to be:
•Advocating for suicide prevention efforts
•Developing and implementing educational strategies
•Developing and implementing marketing and public relations strategies
•Developing and expanding community suicide prevention
•Securing funding for continued suicide prevention efforts

The Kentucky Suicide Prevention Group (KSPG) began utilizing Question, Persuade and Refer: Ask a Question, Save a Life (QPR) Training to provide basic awareness and informational presentations about the signs, risk factors and protective factors related to suicide prevention in 2006. Evaluation of data complied from 3500 people showed that QPR helped raise awareness and perceived ability to act. Several persons involved with each regional community mental health center and the local disaster preparedness teams were trained in QPR since they are likely first responders to mass and individual crises. KSPG has adopted the QPR model as the gatekeeper program in advocating for public awareness. Three internal QPR sessions were offered for Mental Health staff. In addition, KSPG held the first annual QPR instructors conference in March 2007. At that time instructors had the chance to offer tips and learn skills from each other. The group successfully completed plans for providing a newsletter which provides an overview of key components of clinical risk screening and assessment.

MHMR collaborated with the Kentucky Center for School Safety in sponsoring a newspaper insert designed for usage in middle schools and high schools as part of the education curriculum. This insert focused upon metal health, suicide prevention and having good relationships with others.

Other local efforts included:
•Lexington -- The Stop Youth Suicide Campaign held a summit.
•Owensboro -- The Owensboro Suicide Prevention Task Force continued to address suicide in their local community by having monthly meetings and hosting an annual event during the National Suicide Prevention Week in September. They are focusing on post-vention activities for the future.
•Northern KY- The Northern Kentucky Suicide Prevention Group initiated meetings and provided training to persons including clergy, mental health professionals and first responders.

KSPG provided and attended many training opportunities. They hosted the Core Competencies of Community Suicide Prevention as delivered by the National Suicide Prevention Resource Center. Through an agreement with the National Suicide Prevention Resource Center, a week-long training for local suicide prevention coalitions to build skill in establishing and sustaining local efforts. The annual KSPG retreat was held in August. At that time the group established the plan for 2007. In September, KSPG coordinated a State Suicide Prevention Day held in Frankfort. Senator Tom Buford and Representative Mary Lou Marzian addressed the audience as survivors of suicide and commended the group for their efforts of prevention within the state. Finally, KSPG sponsored two sites for National Suicide Survivor Day in November. Both Louisville and Lexington were able to provide a teleconference to survivors.
•Louisville -- The Louisville Suicide Prevention group held monthly meetings with representatives from Family Health Centers, 7 Counties (Mental Health Center), Our Lady of Peace, Jefferson Co Public Schools, the Health Department (HD)and others to discuss suicide prevention activities. Their focus is on increasing awareness about suicide and suicide prevention. Activities included a press Conference for Suicide Prevention week; a city wide survivor conference in recognition of Suicide Survivor Day in November with presenters and the national live telecast of the Survivors of Suicide presentation; held a community suicide awareness education event; a presentation to the pediatric residents at UofL about suicide awareness and action steps they should take in prevention, and provided additional training and suicide prevention materials to all HD clinics.

KSPG is serving as an advisory group to the Dept for Mental Health and Mental Retardation Services (MHMR). MHMR received a $400,000 three-year renewable SAMHSA grant to provide suicide prevention to youth in KY.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaboration with the Department for Mental Health and Mental Retardation on Suicide Prevention Workgroup and Child Fatality Review Team.			X	X
2. Increased public awareness of suicide through media campaigns.			X	X
3. Identification and Coordination of Resources.			X	X
4. Identification of intervention options and training resources.			X	X
5. Enhance Mental Health Initiatives through KIDS NOW!	X		X	X
6. Well Child and Adolescent Preventive Health training for local health department staff.	X		X	X
7. Funding through SAMHSA for youth suicide prevention			X	X
8. KY Suicide Prevention members working with school districts to work with survivors, provide resources and create media opportunities			X	X
9.				
10.				

b. Current Activities

The Dept for Public Health continues to provide funding to the Dept of Mental Health and Mental Retardation to increase efforts in reducing youth suicides. An MCH staff person is a member of KSPG and serves on the Steering Committee. In like, MHMR staff are members of the State Child Fatality Review Team. The KSPG continues utilizing Question, Persuade, & Refer: Ask a Question, Save a Life (QPR) training to provide basic awareness and informational presentations about the signs, risk factors and protective factors related to suicide prevention. Three sessions to certify new QPR trainers were held in May and resulted in over 80 newly certified trainers.

MHMR was awarded $400,000 of SAMHSA funding via the Garrett Lee Smith memorial for youth suicide prevention. This money is awarded for three years and is being utilized to increase youth suicide prevention efforts. With the award of the SAMHSA grant, MHMR has hired a full-time marketing specialist. That staff is working with KSPG in developing a public media campaign to promote suicide prevention with youth. Although the primary focus is youth, the campaign will also address other populations.

Louisville activities include staff trained in QPR trainer classes to increase the number of people trained in the community; creating a resource list for school personnel and medical providers about MH resources; and creating a distribution list of local newsletters, newspapers, list serves and will post articles on a regular basis.
An attachment is included in this section.

c. Plan for the Coming Year
•Planning for a series of focus groups that will assess the needs of survivors
•An awareness survey will be conducted by UK Survey Research Center
MHMR is offering their first comprehensive conference in May--The Kentucky Conference: Advances in Best Practice. Part of the curriculum will include day long sessions by Dr. David Rudd and staff from Frank Campbell's LOSS team.
KSPG is also offering four separate QPR sessions at the conference in an effort to increase our gatekeeper numbers. Dr. Rudd was a featured speaker at the annual Stop Youth Suicide Campaign's Youth Suicide Prevention Conference that was held in Lexington on February 23rd. Dr. Omar was instrumental in organizing and providing quality speakers for this day-long training.
KSPG members are working to implement SOS, Reconnection Youth and CAST in two school districts. The group has also moved forward with the plans from last year and has established a bimonthly newsletter that is sent out to over 1,000 individuals and agencies. The group has re-visited their purpose and has created three additional focus areas for this year:
•Working with survivors
•Creating media opportunities for the group
•Working to provide resources to the community

In addition to the state suicide prevention group, the prevention group in Louisville continues to meet and implement community/media events to raise awareness about suicide and increase understanding about the impact suicide has on family, friends and community.

The Dept for Public Health continues to support MHMR in their efforts to address youth suicide. DPH provides Title V funding and staff members that attend KSPG meetings. Staff also serve on the Steering Committee and provides awareness and prevention materials to LHD staff.

The KSPG will continue previous projects and plan for new interventions. Ongoing activities include the newsletter, which will be offered in hardcopy and also emailed.

Another activity for 2009 will be to find teens where they are. This workgroup will work with the marketing staff person to find ways to reach youth in today's climate of internet use. Information will be offered on My Space, You Tube and other venues that attract young people.

Survivor care will be one focus of work during 2009. Discussion is on-going about doing quilts in

communities and trying to find ways to diminish the stigma associated with suicide. Community Remembrance Days will be organized as well. In addition, focus groups will be held across the state to assess the availability/need for survivor support. The group will help find locations that are willing to participate in these focus groups so that we can get a better picture of what is available to people in the state.

Planned activities for this year include:
•a series of focus groups will occur in the interest of assessing the needs of survivors
•an awareness survey will be completed by UK Survey Research Center
•pictures attained and facilitate a survivor quilt to be used at local and state events

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	61	64	82	70
Annual Indicator	62.4	73.8	60.0	55.4	55.0
Numerator	580	669	452	424	438
Denominator	930	906	753	766	796
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55	60	65	70	70

Notes - 2007
2007 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2007 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2006
KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

2006 data is preliminary and numbers could change. Total birth files have not been received yet, therefore, numbers are lower than expected. The percentage will most likely decrease when files are complete. Due to this, it appears Kentucky has met the Annual Performance Objectives, when in reality, we have not. Therefore, the Objectives have not been increased.

Future objectives were reviewed but are unchanged because the 2006 data is preliminary and number could change.

Data for 2006 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2005
KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2005 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

a. Last Year's Accomplishments
Regionalized Neonatal Care: General Information
Five Kentucky hospitals qualify as Level III Neonatal Hospital facilities, King's Daughters in Ashland (with 1 Level III bed), the University of Kentucky in Lexington, the University of Louisville in Louisville, Norton/Kosair in Louisville, and Suburban in Louisville. A total of 117 beds are licensed for care under the Level III designation. Additionally, 221 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state while the Level III hospitals cluster in the two major population center: Louisville and Lexington.

Kentucky requires a Certificate of Need for NICU beds. Requests must be consistent with the State Health Plan. According to the State Health Plan, the number of Level III NICU beds is determined by a calculation based on the total annual births in the state while the number of Level II NICU beds is based by calculation using the number of total annual births to an area development district.

The Office of Certificate of Need within the Cabinet for Health and Family Services is responsible for working with local hospitals. Currently, the Office of Health Policy encourages hospitals to apply for Level II NICU beds, as more beds in rural areas are seen as more accessible care. Local hospitals must commit to standards consistent with the Guidelines for Perinatal Care, Fifth Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. However, once the CON is obtained, there is no reporting or oversight of these units.

At the recommendation of a state legislator, the Cabinet for Health and Family Services, has re-instituted a Perinatal Advisory Task Force (PATF), which looked at data collection, quality assurance, transparency, and evidence-based guidelines for transfer. Accomplishments include 1) a survey of birthing hospitals regarding their current capacity and policies; 2) a study of regionalization of other states; 3) data from our state on mortality by Level of Delivery hospital (combining of 6 years of data to assure adequate numbers; 4) review of national quality indicators for perinatal care; 5) discussion of a maternal transport system, 6) and drafting of Kentucky-specific Guidelines for Perinatal Care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. On-going training for health professionals working with neonates	X		X	X
2. Perinatal Advisory Task Force designing reporting, oversight, and guidelines for services and transport				X
3. Collaboration with the Kentucky Hospital Association				X
4. Preconceptual health services through WIC, prenatal services,	X	X	X	X

folic acid supplements				
5. Collaboration Family Planning and preconceptual health counseling	X		X	X
6. Support of maternity and prenatal services through the local health department	X		X	X
7. Early Entry into prenatal care	X	X	X	
8.				
9.				
10.				

b. Current Activities

The Perinatal Advisory Task Force has drafted Kentucky-specific Guidelines for Perinatal Care. These guidelines will be reviewed by professional organizations before being finalized and released. The Kentucky Hospital Association has strongly objected to any new document which would constrain the hospitals from providing whatever care their physicians feel is appropriate. At the last meeting, mortality data by level of care, aggregated and linked files for a 6 year period were presented. The Kentucky data is consistent with the national evidence base, that VLBW infants are more likely to survive when treated in Level III NICU's. This information did not dissuade the hospital association from objecting to specific weights for transfer guidelines for VLBW infants. In addition, while there is verbal agreement that a quality collaborative would be desireable, there is no concensus on how to collect that data.

The group was accepting of using Fetal Infant Mortality Reviews as a method for NICU's to participate in quality improvement in their communities.

c. Plan for the Coming Year

Our goal is to move to regional or state-wide quality improvement activities, as well as collection of outcomes for NICU babies, both immediate and post-discharge. One consideration is FIMR case reviews hosted by Level II and Level III NICU hospitals. This will allow them to better identify strengths and weaknesses of the perinatal systems of care in their communities. These case reviews may be presented to Community Actions Teams to develop strategies to address the community's needs.

The Perinatal Advisory Task Force will continue to meet and promote the Kentucky-specific Guidelines for Perinatal Care. Perinatal outcomes and quality indicators will continue to be monitored and reviewed in order to improve perinatal outcomes in Kentucky.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85.8	85.9	86	78	80
Annual Indicator	86.2	74.6	73.5	72.1	71.3
Numerator	47741	39863	39414	39396	39089
Denominator	55413	53425	53646	54614	54821
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	80	80	82	82

Notes - 2007
2007 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2007 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

Notes - 2006
2006 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2006 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

Notes - 2005
2005 data is preliminary and numbers could change.

The calculation of this indicator has changed. There currently does not exist a standard method of calculation set forth by the National Center for Health Statistics and states that have switched to the new certificate are using their own method of calculation. Month prenatal care began is no longer reported on the KY certificate of live birth. Since the adoption of the new standard certificate of live birth in 2004, the data collection for this indicator has changed. Date of first and last prenatal care visit and total number of visits are now reported along with the date of the last menstrual period; therefore, month prenatal care began must be calculated for each record based on several variables. A new method for calculating this indicator was provided to Region IV and adopted by KY and applied to the 2004-2006 data which was based on methodology developed by a programmer with the National Center for Health Statistics. This could be a possible reason for the decline observed.

a. Last Year's Accomplishments
The Prenatal Program serves pregnant women in Kentucky who are in need of prenatal services through local health department prenatal clinics or through referrals to an appropriate service

provider. The Department for Public Health encourages care in medical homes whenever possible. The mission of the prenatal program is to improve maternal health and pregnancy outcomes through the provision of prenatal care for those who might not otherwise receive it. Any pregnant women at or below 185% poverty income, a KCHIP eligible person at or below 200% poverty income, or those without a secondary payment source shall be assured that these maternity services are provided. All health departments can provide prenatal education, counseling and screening.

At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed.

Local health department staff continue to provide counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program. In addition, local health department staff make an appointment or a referral for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services.

Some local health departments have paid for prenatal services out of their community funds for uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than others. The Division of Adult and Child Health Improvement has attempted to alleviate some of this financial burden by allocating specified funds to the local health departments.

The DPH conducted a PRAMS (Pregnancy Risk Associated Monitoring Systems) pilot study following the guidelines from the Centers for Disease Control and Prevention (CDC) PRAMS core and standard questionnaires. Questions on access to care were included in the PRAMS Pilot survey and 600 surveys were sent out and sampling was conducted from September through November.

Emerging Issues: Prenatal coverage for undocumented/ uninsured women. There were 7,109 pregnant women utilizing Medicaid Presumptive Eligibility in FY06. These pregnant women have limited or no resources to obtain pregnancy services and many do not ultimately qualify for Medicaid services. There is an increase in the number of pregnant women seen in Local Health Departments without a payment source and in need of expensive specialty services for conditions such as diabetes. We provide limited funding to health departments from our Title V MCH Block grant to serve these pregnant women who have no other sources of coverage; however, the funds are insufficient to support the need, and the need continues to grow. However, it is more cost-effective to pay for prenatal care, than to pay the bill for adverse birth outcomes that are more likely without prenatal care.

Prematurity Prevention. The KY Department for Public Health was selected through a competitive process to partner with the National March of Dimes and Johnson & Johnson Pediatric Institute in an initiative called "Healthy Babies Are Worth The Wait". This is a national demonstration project where we have chosen three communities to work on prematurity prevention with multidimensional, broad-based interventions. Over a three year period, this initiative aims to show a significant decrease in the number of babies born prematurely in the intervention sites. This project has national visibility and is the only project of this kind in the nation. There were three presentations on this initiative at the recent American Public Health Association meeting in Washington DC; Dr. Shepherd has been invited to present on this initiative in 4 other states.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support of maternity and prenatal services through the local health department funded by Title V	X		X	X
2. Presumptive Medicaid eligibility for pregnant women in collaboration with Medicaid Services		X	X	
3. Continuation of Substance Abuse Cessation project funding through KIDS NOW!		X	X	
4. Collaboration between Comprehensive Care Centers (Kentucky's mental health providers) and local health departments			X	X
5. HANDS Home visitation services	X	X	X	
6. Tobacco cessation for pregnant women including the Quit-Line	X	X	X	X
7. Centering Pregnancy Programs	X	X	X	
8. Healthy Start program in Whitley Co and the Louisville Metro area	X		X	
9.				
10.				

b. Current Activities

Over 400 completed PRAMS surveys were returned to DPH and the data analysis is currently being completed. Information should help to identify barriers to early entry into prenatal care. This information will be reviewed and interventions will be identified that can be utilized statewide to develop strategies to increase early entry into prenatal care.

DPH has verified the lower rate in early entry into prenatal care with the changes in data collection method (see notes). Now that it is verified, we are looking further into our data to determine strategies for addressing this problem.

The University of Kentucky Area Health Education Center (AHEC) and the North Central AHEC works to educate Latino and African-American individuals about important, culturally relevant topics related to health promotion and disease prevention, including preterm birth prevention; and, develop and maintain a network of trained, dedicated lay health workers who will disseminate culturally and linguistically appropriate information about health. Education will be targeted toward prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.

An attachment is included in this section.

c. Plan for the Coming Year

The DPH plans to repeat an additional PRAMS pilot study with the intention of applying for CDC funding when grant applications will be available.

Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.

DPH is working collaboratively with partners such as the March of Dimes (MOD), Kentucky Perinatal Association (KPA), physicians, hospitals and the Kentucky Folic Acid Partnership (KFAP) to achieve the following goals:
-Raise public awareness about the problem of prematurity
-Educate pregnant women to recognize signs of premature labor

-Assist health care practitioners to improve prematurity risk detection and address risk-associated factors
-Expand access to healthcare in order to improve prenatal care and birth outcomes

University of Louisville contracts with the DPH to provide a yearly Prenatal and Postpartum three day training sessions and a yearly prenatal update to educate public health nurses within the local health departments.

Kentucky's Folic Acid Partnership (KFAP) partners with the DPH to provide awareness and technical assistance about folic acid to women of child bearing age and pregnant mothers. This Partnership has also expanded their activities to include information regarding prematurity prevention and smoking cessation.

DPH has recently been awarded a $254,000 grant from the Anthem Foundation to develop a Smoking During Pregnancy Cessation Project in nine rural counties of eastern Kentucky. The goal of reducing smoking during pregnancy in these nine counties is hoped to lead to a reduction in low birth weight and preterm births as well as fewer perinatal deaths in the targeted areas. This project will serve as a pilot and will provide information needed to develop statewide intervention strategies to reduce smoking during pregnancy.

The "Healthy Babies Are Worth The Wait" Prematurity Prevention Partnership is a three-year initiative, which began implementation in 2007, to target "preventable" preterm births by utilizing evidence based clinical and public health interventions in three communities of Kentucky. The goal is to reduce the rate of singleton preterm birth in the sites by 15%.

Perinatal Advisory Task Force was convened following a resolution from the legislature to address the issues of: (1) Perinatal Voluntary data reporting and quality improvement process (2) Kentucky Guidelines for Perinatal Care (3)Transport guidelines from Level II to Level III NICU's, and (4) A system of accountability for hospitals and providers delivering care to mothers and neonates in Kentucky. Currently hospitals agree to follow the national Guidelines for Perinatal Care (AAP, ACOG) when they apply for a CON, but once the CON is granted, there is no assurance or monitoring to see if they are providing quality care.

D. State Performance Measures

State Performance Measure 1: *Decrease the death rate for children age 0-18 due to unintentianal injury and/or violence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				9	9
Annual Indicator	7.5	11.0	10.9	8.3	6.2
Numerator	78	116	114	87	65
Denominator	1042110	1052419	1049314	1052939	1052939
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	8.5	8.5	8	7.5

Notes - 2007
2007 data is preliminary and numbers could change.

Notes - 2006
2006 data is preliminary and numbers could change.
2005 population estimates were used for the denominator. The 2006 population estimates will not be available until late summer of 2007.

Notes - 2005
2005 data is preliminary and numbers could change.

a. Last Year's Accomplishments
The Child Fatality Review and Injury Prevention Program was created in 1996 to address the deaths of Kentucky's children aged 0-17 years. The goal is to learn from the deaths of each child in hopes of implementing strategies to prevent similar deaths in the future. Each county coroner may convene a local child fatality review team to help in determining the accurate cause/manner of death. These teams consist of staff from the local health department, local Department for Community Based Services (DCBS) and law enforcement, and others such as EMS, attorneys, doctors, fire departments to ensure the review is complete and accurate. Reviews identify risk factors and opportunities for prevention so that other children can be saved. Information from the reviews is aggregated at the state level to look for trends and clusters. The information is used to develop prevention strategies to be implemented on a local, and sometimes, state level. All health departments offer grief counseling to families of children who have died; trainings and reporting for the grief counseling are a part of the CFR program.

Kentucky Department for Public Health staff participated on the Kentucky Center for School Safety Advisory Council through the Kentucky Center for School Safety (KCSS). The purpose of the School Safety Advisory Council (SSAC) is to ensure services provided by the Kentucky Center for School Safety address the needs and concerns of professionals, students, parents, and other Kentucky citizens. Recommendations from this council has, and continues, to assist the Center for School Safety in refining its implementation plans, services, publications, and activities.

Last year, ASK (Ask Saves Kids -- Are there guns in the homes where your child plays) Day in Kentucky was held. This is a program geared towards gun safety. Gun safety information was provided to media through Level I medical center emergency departments. In addition to media information, some gun locks were distributed.

Co-sleeping was addressed due to many infant deaths that occur on couches, in recliners and in beds. Co-sleeping on couches and in recliners may cause even more deaths than co-sleeping in beds. In addition to co-sleeping, crib safety was addressed, both getting caught between slats and also cribs that did not meet CPSC standards. Special education efforts were aimed at church nurseries due to issues related to unsafe cribs. Local child fatality review teams continued to review sleeping related deaths to identify education opportunities throughout the state.

The Department for Public Health partnered with the Department for Community Based Services to complete a statewide SIDS prevention initiative. "Onesies" were sent to every Kentucky hospital that delivers babies. Each "onesie" was imprinted with a safe sleeping message. The front read, "Safe Sleep, This Side Up" and the back read, "Roll Me Over Please". They were printed in English and Spanish and provided an opportunity for nursing staff to educate parents about sleep positioning and the importance of a safe sleeping environment for their newborn.

The Department for Public Health worked with law enforcement, Alcohol Beverage Control, the Governor's Highway Safety Program, the Division of Mental Health and Substance Abuse, and the Department of Education to establish goals, timelines and discussed collaboration among agencies. They worked together to disseminate the Ad Council/PSA Campaign: "Start Talking Before They Start Drinking" as a method of preventing underage alcohol/drug use in Kentucky.

Kentucky's current ATV laws require that:
Helmets be worn when ATVs are driven on public property (unless they are being used for

commercial purposes),
Engine size limits of 70 cc for youth under 12 years old and 90 cc for youth 12 to 16, and
No ATVs be ridden on public roads, unless for commercial purposes or to cross a highway.

The Kentucky General Assembly passed a Booster Seat bill during the 2008 legislative session. The bill requires that children under age 7 and between 40 and 50 inches in height be secured in a child booster seat. The law becomes effective July 15, 2008. Warnings will be issued by law enforcement during the first year.

A copy of the 2005 Child Fatality Review Report is attached.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child Fatality Review and injury Prevention program.		X	X	X
2. Healthy Start in Childcare program to work with preschools, assuring training and safety in the preschool setting.	X	X	X	X
3. Injury Prevention Partners including Safe Kids Coalitions, Poison Control Center, the SIDS Alliance, Kentucky Injury Prevention Research Center, and KY Center for School Safety.			X	X
4. HANDS voluntary home visitation program	X	X	X	X
5. Substance Abuse education and treatment	X		X	X
6. Legislation for Child Booster Seats, Safe Haven, ATV Helmet useage, Graduated Driver's License, and Primary Seatbelt		X	X	X
7. Partnership with the Dept. for Education for Coordinated School Health		X	X	X
8. Partnership with Prevent Child Abuse Kentucky and the Department for Community Based Services		X	X	X
9. Training provided to Well Child and Adolescent Preventive Health Nurses and Oral Health providers to recognize the signs of Domestic Violence				X
10. Injury Prevention programs including Child Passenger Safety Seat Checks, ATV and Hunter Safety classes, Back to Sleep campaign, Smoke Alarm useage, Safe Sleep Environment, SIDS, Shaken Baby, Underage Drinking, Bullying, and Seatbelt Useage	X	X	X	X

b. Current Activities
The University of Louisville, Department of Pediatrics created the Division of Pediatric Forensic Medicine in September 2007. The program is the first in Kentucky that allows pediatricians and medical providers to directly access experts in child abuse before contacting law enforcement and child protective services. The staff currently consists of two forensic pediatricians, a social worker and a forensic nurse. Each case of significant abuse can require 10 to 30 hours of investigation including caregiver interviews, examining and photographing the child, reviewing records, producing court-worthy documents and providing court testimony.

The Injury Prevention program in the MCH Branch and the Emergency Preparedness Branch have been collaborating on brochures to help families plan for disasters. Emphasis has been placed on families with special needs. The brochures were printed and distributed. A copy is attached.

A continous strategy is public information/education. This is accomplished through the Cabinet for Health and Family Services Office of Communications. For example, prior to the July 4th holiday, a series of 6 safety public education articles were released. The topics included West Nile Virus prevention, Fireworks safety, Boating safety, Sunburn/Skin Cancer prevention, Food safety and Drowning prevention. A copy of the Drowning prevention is attached.

Staff continue to participate on the Center for School Safety Advisory Council through the KY Center for School Safety.
An attachment is included in this section.

c. Plan for the Coming Year
The Kentucky SAFE KIDS Coalition received the $25,000 fire grant which is funding activities in Barren, Metcalfe and Monroe counties during this year. Kentucky's Injury Free Coalition for Kids of Lexington received another $25,000 that is being used in Fayette county to address disparities in the African American and Hispanic communities.

Fire related deaths during 2006 will produce more emphasis on fire safety education. One county experienced the deaths of six children in one incident which will increase fire deaths in our data and spur more education efforts.

The bulk of injury related activities in Kentucky revolve around transportation crash related injuries and deaths.
Data will be reviewed for progress in this area with the passage of the Graduated Driver's Licensing for teens that became effective October 1, 2006 and the Primary Seatbelt legislation that became effective January 1, 2007.

The KY Injury Free Kids Coalition will continue to address injuries in the African American and Hispanic communities throughout 2008-09. Based on a combination of injury data analysis and community partnerships, they will focus on five zip-code locations in Lexington. Those locations include a low-income area with the highest birth rate in the city, an area with a large population of Hispanic residents, the area with the highest number of social services reports for child abuse and neglect, and one location that houses a large population of foreign graduate students. The injury/safety issues that are being addressed in these identified areas include:
•Child passenger safety for children under age seven.
•Graduated drivers licensing for teens ages 16 and 17.
•Playground safety.
•Safety issues at child care centers.
•Prevention and early identification of injuries related to child abuse.

These identified issues will be addressed by providing hands-on education, presentations on safety issues to interested groups, continuing to work with existing groups to address safety, finding funds to build safe playgrounds, etc.

In addition to the Injury Free Kids Coalition, Kentucky is fortunate to have six counties that have applied for funding for their SAFE KIDS coalitions. These communities have been funded in the past and will be successful in securing funding for 2008. These groups do most of their work with child passenger safety, but do address other injury issues as well.

The Kentucky General Assembly passed a Booster Seat bill during the 2008 legislative session. The bill requires that children under age 7 and between 40 and 50 inches in height be secured in a child booster seat. The law becomes effective July 15, 2008. Warnings will be issued by law enforcement during the first year. The Department for Public Health and our injury prevention partners will provide education and outreach regarding the new law.

An attachment is included in this section.

State Performance Measure 2: *Reduce the rate of substantiated incidence of child abuse, neglect, or dependency.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	17	16	15	9.4	14
Annual Indicator	9.4	18.4	18.9	19.1	18.5
Numerator	9796	18275	18827	19003	18469
Denominator	1042110	993875	996407	996407	999531
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	12	12	10	10

Notes - 2006
Data is from TWIST data from 7/1/2005 to 6/30/2006. Denominator is total children in Kentucky ages 0 to <18. Numerator is total number of investigated children substantiated for child abuse and/or neglect. Due to staff changes, data may not have been consistently reported in previous years, which could explain the varying numbers from 2002 to 2004. Data from 2004 to 2006 was reviewed with DCBS staff and verified. Data source is Child Abuse and Neglect of Child Fatalities and Near Fatalities, State Fiscal Year 2006 (July 1, 2005 to June 30, 2006). This report is submitted annually to the governor.

a. Last Year's Accomplishments
The HANDS program is coordinated by the Department for Public Health. The purpose of this program is to provide home visitation to overburdened first-time families to assist them in meeting the challenges of parenting beginning prenatally and continuing during the child's first two years of life. Anticipated results are to achieve positive pregnancy outcomes, to improve the health and developmental outcomes for children, to have children in healthy and safe homes and to reduce the likelihood of child abuse and neglect over the long term. HANDS began in eleven pilot counties in December of 1998 and in the spring of 1999, four additional counties were added. In 2001, an additional thirty-two counties were added bringing the total participating counties to forty-seven. 2002 brought about 54 additional new counties totaling 101 participating counties and in 2003, statewide coverage of all 120 Kentucky counties was achieved.

According to the KIDS NOW Early Childhood Initiative Summary dated March 2008, in FY 2008, 9,714 families participated in HANDS. All 120 counties were participating and 4543 assessments were conducted, 42,129 professional home visits and 66,028 paraprofessional home visits were conducted.

Birth indicators based on 2002-2005 data showed HANDS participants to have fewer premature infants, fewer low and very low birth weight infants, when compared to other first time parents who did not participate in the weekly home visitation program. Likewise, Infant Mortality rates per thousand for HANDS (2.1) compared to the statewide Kentucky (6.8) rate was significantly lower in 2005. A study of ER usage showed that of 104 counties studied, HANDS recipients demonstrated lower ER usage rates in 102 counties. Substantiated cases of child abuse or neglect are significantly lower in the HANDS population than the state average, particularly considering someone is visiting these high risk families once a week.

DPH also works closely with the Department of Community Based Services, Division of Protection and Permancy and Prevent Child Abuse KY to promote the prevention of child abuse, neglect and maltreatment and help families provide stable, nuturing homes. These efforts include parent training, mentoring, prevention education and in-home visits.

In April 2008, trainings were provided by Prevent Child Abuse KY in several Kentucky counties. Training topics included Abusive Head Trauma, Accidental vs. Non-Accidental Skeletal Identification, Demystifying the Department for Community Based Services (DCBS) Process and Using the Child Fatality Review Team to learn prevention strategies. The training targeted health care professionals, HANDS providers, School Nurses and Child Fatality Review team members including Coroners, DCBS and local health department staff, law enforcement and prosecutors. CEUs were provided.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuation of HANDS Voluntary Home Visitation Program	X	X	X	X
2. Child Fatality Review Data System for on-going surveillance of child deaths			X	X
3. Healthy Start in Childcare program to work with preschools, assuring training and saftey in the preschool setting			X	X
4. On-going monitoring of HANDS data and HANDS evaluation process.				X
5. KIDS NOW! Early Childhood Mental Health and full implementation of the Mental Health in Child Care Initiative.	X		X	X
6. Training provided to Oral Health providers and local Health department Nurses to recognize the signs of Domestic Violence			X	X
7. Substance Abuse education and treatment	X		X	X
8. Partnership between the Department for Public Health, the Commission for Children with Special Health Care Needs and the Department for Community Based Services for injury prevention programs			X	X
9. Partnerships with Kentucky Injury Prevention Research Center, Prevent Child Abuse KY and KY Center for School Safety.			X	X
10. Perinatal Depression Study thru HANDS (HRSA Grant)	X	X	X	X

b. Current Activities
Over the past year emphasis has been placed on inclusion of perinatal depression screening using the Edinburgh Depression Screen. Upon training, professional home visitors complete the Edinburgh Depression screening at three intervals (6-8 months prenatal, 6-8 weeks postpartum and when the child is 8-12 months old). Positive screens are referred to local comprehensive care centers for assessment/treatment by a mental health specialist. These mental health professionals also received extensive training on parent-infant dyadic therapy and cognitive behavioral techniques. HANDS sites along with the mental health agencies have been given pamphlets, videos and books regarding perinatal depression for resources. Addressing perinatal depression is an investment in the health and wellness of all Kentuckians and will result in improved health of women during the perinatal period, improved birth outcomes, and improved social emotional health of parent and children.

The 2nd Annual HANDS Fall Retreat was held in October 2007 with over 325 participants. National and state speakers were utilized to help HANDS staff obtain required training. The Keynote speaker was Adolph Brown.

Refresher courses, in regards to curriculum and supervision, have occurred across the state to help ensure that basic skills and strength-based strategies are being utilized by staff.

The HANDS home visiting program was one of the featured articles in the June 2008 AMCHP Pulse on Injury and Violence Prevention.
An attachment is included in this section.

c. Plan for the Coming Year
The HANDS program is developing new public relation materials with focus on prenatal entry into the program.

Work has begun on a web-system for centralization and up to date information on technical assistance site visits documentation.

Continued efforts will be given to:

Development of Technical Assistance Training

On-line home visiting safety training module

On-line orientation into HANDS

Incorporation of ongoing child development assessment- HELP (Hawaii Early Learning Profile)

Kentucky Statute KRS 620.030 mandates that anyone who has reasonable cause to believe that a child is abused or neglected shall immediately make a report to proper authorities including local law enforcement, the cabinet or the commonwealth or county attorney. The 24 hour abuse or neglect hotline number to call to make a report of abuse or neglect is 1-800-752-6200. The Cabinet for Health and Family Services, Division of Protection and Permanency (DPP) is the agency in Kentucky responsible for receiving and investigating cases where child abuse or neglect is alleged to have occured.

Research has shown that parents/caregivers that have strong coping skills and standby support are more likely to provide safe homes for their children. Prevent Child Abuse KY offers a toll-free hot line - 1-800-CHILDREN - that links parents and caregivers to a network of services that offer the right assistance.

DPH requires that each nurse that will be working in a local health department Well Child Clinic complete a 30 hour course that includes recognizing, reporting and documenting child abuse and neglect. A preceptorship is also included before the RN receives certification.

DPP staff are an active part of the State Child Fatality Review team. They encourage and support local DPP staff participation in the child death review process. Upon receiving notification of a child death, DPP evaluates if child abuse/neglect is a factor and will protect other children remaining in the home that may be at risk.

Web-trainings have also been developed by DPP staff and offered to local health department nurses and staff. They include the "Skeleton and Abdominal Injuries", "Bruises, Bites and Burns" and "Newborn Drug Screening". Other web-based "MECAN" courses are under development. These Courses are available at TRAIN.ky.gov & CEUs are offered.

The KY Chapter of the American Academy of Pediatrics (KY AAP) has also been active in the prevention of child abuse and neglect with DPP and Prevent Child Abuse Kentucky. The CARE (Child Abuse Recognition Education) program, through a HRSA grant entitled Healthy Tomorrow's Partnership for Children, trains medical professionals to recognize the signs and symptoms of child maltreatment and abuse.

The Dept for Public Health, the Division of Protection and Permanency and Prevent Child Abuse

KY will continue to collaborate with other community partners to provide parent/caregiver training and prevention education that will enable vulnerable families to become safer and stronger.
An attachment is included in this section.

State Performance Measure 7: *Increase the percent of women of childbearing age that present to a local health department that receive a preconceptual service.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12	82
Annual Indicator			77.6	80.6	83.4
Numerator			177301	184168	158736
Denominator			228567	228567	190233
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82	85	85	90	90

Notes - 2006
This indicator has been changed since it was first developed in last years grant application. The 2005 data reflects women aged 15-44 in minority populations (any race/ethnicity except for Non-Hispanic Whites) that presented to the Local Health Department for a preconceptual service. This indicator was changed for 2006 to include any woman aged 15-44 regardless of race/ehtnicity that presented to the Local Health Department for any reason and received a preconceptual service. This indicator was changed due to the very small numbers of minority women of childbearing age presenting to the Local Health Department for services, and the new indicator will provide a better measure for women of childbearing age that receive preconceptual services regardless of their reason for presenting to the Local Health Department.

Notes - 2005
Data reflects women of disparate populations who received preconceptual care in the Local Health Department.

a. Last Year's Accomplishments
The KY Department for Public Health houses many diverse programs that support CDC's preconceptional recommendations by developing interdepartmental initiatives focusing on interconceptional care for women. The collaborative initiatives recognize that preconceptional care should not be limited to a single visit. All DPH health care programs identify that they have an impact on a women's optimal health and potential outcome of any planned or unplanned birth. Opportunities to discuss preconceptional health with patients during each particular program's clinical visits are identified through collaborative agreements during the developmental and approval process for all DPH policies and guidelines.

One such DPH program identified to have the most significant impact by reaching the greatest amount of women would be the Title X/Family Planning Program. Housed within the Division of Women's Physical and Mental Health, the Title X/Family Planning Program offers a full array of reproductive healthcare services for individuals of all ages. Funding for family planning services is made available through federal Title X funds allocated to local health departments.
• Services include: client education, counseling, history, physical assessment and laboratory testing, fertility regulation, infertility services, pregnancy diagnosis and counseling, adolescent services, gynecologist services and sexually transmitted disease testing and treatment
• Low-income under or uninsured females less than age 21 identified as having abnormal gynecological cancer detecting exams (breast and cervical) are provided treatment via use of Title V funds
• Special emphasis on preconceptional health, and benefits of birth spacing is given during the

preventive health counseling sessions
• In calendar year 2007, 111,462 women, men, and adolescents were served through the Title X program

Family Planning clients are provided counseling annually to promote preconception health. Counseling supports the recent CDC recommendations for preconception health and includes (See Attachment):
• Eat a variety of foods from each food group
• Take 400mcg of Folic Acid daily to help prevent birth defects of the brain and spinal cord
• See your dentist regularly to prevent dental infections and tooth decay.
• Keep yearly routine medical visits up to date, including a complete medical history, laboratory screening tests, updated immunizations, and a physical exam that includes a cervical cancer screening to detect early precancerous conditions of the cervix
• Check your home and work for any environmental substances (i.e. lead exposure) which could prevent normal growth of the fetus as well as physical and mental defects
• Stop drinking alcohol, smoking and taking drugs
• Exercise 20 minutes 3 or more times a week to help reduce the risk of heart attacks, strokes, high blood pressure, obesity, osteoporosis (brittle bones), and arthritis.
• Vaccinate before you become pregnant, as it will protect your future children from harm. Some vaccines must be given at least 3 months before you become pregnant, and you may need to use a birth control method for at least 3 months after you are vaccinated. Infections can harm both the mother and the baby. Some infections can cause severe birth defects or illness in the baby. If you have not been vaccinated for diseases like measles, mumps, or rubella, tell your doctor.

Special initiatives targeted to service populations identified as having high social and medical risk for unintended pregnancy or poor birth outcomes include:
• One Title X clinic targeted to low income under insured Hispanics served 670 individuals adding to a statewide total of 8150 Hispanic users. This statewide total was a 11% increase from calendar year 2006.
• Community outreach efforts in urban areas contributed to providing services to 13,032 African/American clients.
• A targeted Appalachian region known to have a higher STD and teen pregnancy rate, have proven with the Pike County Male Special Initiative Project that services need to expand beyond the local health department clinic, by reaching not only a college based clinic, but also an in-school program for middle school males who are taught goal setting and self-esteem skills. Total services provided to males age 15 and below were 3,268 and 152 males over age 15.
• Two central KY Title X initiatives focus on teen pregnancy prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Education and training for health care professionals in cultural diversity		X	X	X
2. Family Planning counseling and interconceptual spacing of children	X	X	X	
3. Access to care and early entry into prenatal care	X		X	X
4. WIC and Nutrition counseling	X	X	X	
5. Substance Abuse education and treatment	X	X	X	
6. Smoking cessation counseling	X	X	X	
7. Preconceptual counseling and Folic Acid supplements	X	X	X	
8.				
9.				
10.				

b. Current Activities
Kentucky received $ 5,508,269 in federal Title X funding for FY08. Kentucky funds 170 Title X clinics, with the majority of this funding allocated to local health departments to assure access to family planning services throughout Kentucky's 120 counties. Additionally, local health departments may opt to use a portion of their federal Title V Block Grant allocation to support family planning program efforts in their community. In FY 07 local health departments used $995,979 of Title V funds to supplement their family planning programs. All Title X delegate agencies must offer all methods of FDA approved contraceptives, including emergency contraceptive pills. Title X funding does not fund abortions.

Recent interconceptional collaborations with other MCH programs include: a.) All family planning women receiving a pregnancy test also receive a lead exposure verbal risk assessment. Those women identifying with a high risk are recommended for follow up screening; b.) Women of childbearing age are counseled on the importance of folic acid and receive folic acid supplementation; and c.) Kentucky's largest metropolitan area, Jefferson Co benefits from the Healthy Start Program, a federally funded initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes. The program focuses on Five Core Service interventions: direct outreach; case management; health education, interconceptional care; and screening for depression.(See Attachment)

An attachment is included in this section.

c. Plan for the Coming Year
Preconception health care is defined as a set of interventions that identify and modify biomedical, behavioral, and social risks to a woman's health and future pregnancies. The goals of preconception health care are screening for risks, health education and promotion, and interventions to address identified risks for a healthy life and a healthy pregnancy outcome. The fetus is most susceptible to developing certain problems in the first 4-10 weeks after conception, before prenatal care is normally initiated. Several effective preconception interventions, such as smoking cessation, obesity control, folic acid supplementation and some medication adjustments take months to implement and therefore must begin long before conception.

Kentucky's 2009 Family Planning Program's goals are:

To assure access to comprehensive quality family planning services to individuals, families, and communities through outreach to hard-to-reach or disparate populations and partnering with community-based health and social service providers.
To provide comprehensive reproductive preventive services to enhance the health of Kentucky women and families as demonstrated in improved prematurity rates, STD prevalence, cancer screenings and decreased teen pregnancy and birth rates.
To assist women, teens, and men to prevent unintended pregnancy and plan healthy pregnancies.

To help meet these goals, Title X the program must continue to market services through community participation committees and community plans; prepare or recruit additional providers; continue outreach to hard-to-reach and vulnerable populations in non-traditional service sites already established; and expand non-traditional sites to new areas.

The Healthy Start Program will continue to:

• Increase the number of disparate populations seeking services particularly African-American pregnant clients
• Reduce poor pregnancy outcomes such as low birth weights
• Increase the number of women initiating prenatal care in the first trimester

• Increase the number of women receiving preventive care services after delivery
• Zero infant mortality to Healthy Start Participants

DPH Programs such as MCH, Title X and Healthy Start will continue to collaborate on developing strategies to teach providers how to identify and utilize preconceptional reimbursement codes that will provide an avenue to collect data and track counseling. Title X/Family Planning clinics will continue to provide medical counseling, all FDA approved contraceptive choices, preconceptional counseling, Pap tests, and STD testing including HIV. The new CDC recommendations regarding preconception health care, will dictate how DPH will continue to collaborate interdepartmentally to identify and strategize goals and objectives to assure healthy maternal and child health outcomes.

State Performance Measure 8: *Reduce the percentage of live births that are preterm.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				16	14
Annual Indicator	14.4	14.4	15.0	15.6	15.8
Numerator	7792	8026	8398	8802	8802
Denominator	54024	55779	55990	56463	55582
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	12	12	10	10

Notes - 2007
2007 data is preliminary and numbers could change. Calculations for this indicator are currently being reviewed as there could be problems with the coding in the program for calucalting gestational age for each record, therefore the 2007 numerator actually reflects the 2006 numerator. We are currently working with staff at the NCHS for correcting this issue.

Notes - 2006
2006 data reflects data from 2005. The 2006 data is not yet available as we are waiting on updated coding from the National Center for Health Statistics for calculating and imputing gestational age. We anticipate receiving the updated code in early July and will report the 2006 data at that time.

Notes - 2005
2005 data is preliminary and numbers could change.

a. Last Year's Accomplishments
Preterm live births increased 17% over the last six years in Kentucky.
Triplets and higher multiples had the highest percentage of preterm births followed by twins.
Preterm births for singletons have increased slightly over time yet remains far below the rate of multiple births.
There continues to be a racial disparity with Non-Hispanic Blacks having a preterm birth rate almost one and a half times that of Non-Hispanic Whites.

Kentucky remains below the Nation in the percentage of women receiving prenatal care beginning after the first trimester; this is true for Whites and African Americans.

DPH is working very hard with partners such as the March of Dimes (MOD), Kentucky Perinatal Association (KPA), physicians, and the Kentucky Folic Acid Partnership (KFAP) to achieve the following goals.

To raise public awareness of the problems of prematurity
To educate pregnant women and their families to recognize the signs of preterm labor
To assist health care practitioners to improve prematurity risk detection and address risk-associated factors
To expand access to health care in order to improve prenatal care and infant health outcomes

Accomplishments

• Development of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit and implementation at three intervention sites in Kentucky to assist these communities to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention.
• The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.
• A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.
• Dr. Ruth Ann Sheperd, Title V Director, continues to present an awareness prematurity campaign to prenatal health care providers and consumers in Kentucky and has also presented nationally at the American Public Health Association and March of Dimes State and Regional meetings.

"Healthy Babies are Worth the Wait" is helping Kentucky's babies get the best possible start in life. Working with health care providers and community partners, the program helps ensure that Moms-to-be have the care and information they need to maintain healthy, full-term pregnancies. "Health Babies are Worth the Wait" is an Initiative of the Prematurity Prevention Partnership and includes the March of Dimes, Johnson & Johnson Pediatric Institute, and the Kentucky Department of Public Health. The goal of the Initiative is a 15% reduction in preterm births in the Intervention Sites over the 3 year intervention period.

For more information about the Initiative visit the official website of "Healthy Babies are Worth the Wait" at prematurityprevention.org

• The KPA hosted their Prematurity Summit in June 2007. Topics include: Improving Outcomes through Maternal Nutrition, Raising Awareness of Prematurity, Decision Making for 36 week preterm, Neonatal Abstinence Syndrome, "Healthy Babies are Worth the Wait", Scope of the Program of Late Preterm Birth, Legislative Issues Surrounding the Late Preterm infant and Brain Development in the Late Preterm Infant.
• A Perinatal Advisory Task Force was developed and first met in May of 2007.
• Statewide prematurity awareness activities performed by the Kentucky Folic Acid Partnership included 388 activities with 1,615,244 participants.

Dr. Ruth Ann Shepherd, Title V Director, has been active in The National Quality Forum, Perinatal Steering Committee. This very distinguished group of experts are developing national voluntary consensus standards for Perinatal Care. The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborative efforts with KY Perinatal Association and the March of Dimes		X	X	X
2. Folic Acid Partnership Statewide Prematurity Awareness campaign			X	X
3. HANDS Home Visitation Program	X	X	X	X
4. University partnerships			X	X
5. Training provided to health care professionals			X	X
6. Development of a Prematurity Tool Kit and a speaker's bureau			X	X
7. Title V Director's prematurity presentations			X	X
8. "Babies are Worth the Wait" demonstration project with the March of Dimes and the Johnson & Johnson Pediatric Institute			X	X
9.				
10.				

b. Current Activities

DPH provides a yearly Prenatal/Postpartum Training and Prenatal Update for LHD staff. Sessions will be provided to focus on prematurity prevention, utilization of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit, and providing prenatal classes to the community. DPH will also encourage using the Tool Kit across the state as a model intervention to assist communities and providers to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention.

The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.

A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to assist uninsured pregnant women in need of prenatal services.

Statewide prematurity awareness activities performed by the KY Folic Acid Partnership through March 2008 included 59 activities with 161,082 participants.

The Perinatal Advisory Task Force has drafted Kentucky specific Guidelines for Perinatal Care that is modeled after the National Guidelines for Perinatal Care.

c. Plan for the Coming Year

• The Department for Public Health will provide a yearly Prenatal/Postpartum Training and Prenatal Update for LHD staff with sessions relating to prematurity prevention.
• The prenatal program in the local health departments continues to assess prenatal patients for preterm risk at the initial visit, and return visits for those women assessed at risk for preterm labor.
• A guideline on preterm birth prevention continues to be included in the prenatal section of the Public Health Practice Reference to assist local health department prenatal staff. The mission of the prenatal program in the local health department is to assist pregnant women to access prenatal care services regardless of payor source. Title V funding is allocated each fiscal year to health departments to assist uninsured pregnant women in need of prenatal services.
• The Perinatal Advisory Task Force will continue to meet and implement the Kentucky specific Guidelines for Perinatal Care.

• The Department for Public Health will encourage the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Tool Kit across the state of Kentucky as a model intervention to assist communities and providers to deliver a universal message/awareness about the issue of premature birth in Kentucky and interventions targeted toward prevention.

The Kentucky Folic Acid Partnership (KFAP) started in September 1999 and has now expanded to 92 members representing 56 agencies/organizations and businesses. The KFAP encourages community activities to educate about the use of folic acid to prevent birth defects and has expanded their role to educate communities about preterm birth prevention. In FY08, there were 511 activities provided that reached 6,242,954 participants. Recent activities include PSA's, newspaper articles, pregnancy workshop classes, and health fairs.

The Kentucky Folic Acid Partnership (KFAP) held its annual meeting and Prematurity Summit June 1-3, 2008. Topics included: The Best of the Guidelines in Prenatal Care, Pregnancy, Prematurity and Polysubstance Abuse, Developmental Care for Preterm: Is it important or Useless?, Follow-up High Risk and Premature Infants for Public Health Nurse and Other Health Care Profesionals, Challenges for Obstetricians in Preventing Late Preterm Birth, and Bereavement in the NICU. CEUs and CMEs were offered.

State Performance Measure 9: *Percentage of foster care children served by the Commission for Children with Special Health Care Needs (CCSHCN)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				20	30
Annual Indicator			2.5	2.8	4.9
Numerator			164	182	368
Denominator			6600	6600	7500
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	50	60	60	60

a. Last Year's Accomplishments
The Commission and the Dept of Community Based Services (DCBS) continued exploring and developing how best to identify and respond to the health care needs of the medically fragile foster children. Nurse Liaisons 1)interpret medical records, 2)serve as consultants to SWs and foster care families on medical issues 3) participate in monthly home visits for assessment purposes, 4)instruct foster families and SWs on medical procedures, treatments and expected outcomes, 5) assure establishment and maintenance of updated, current "medical passport" 6) enhance care coordination of all services, e.g. medical, dental and behavioral health 7) track the utilization of all health services, including prevention and wellness programs, 8) serve as consultants on medical issues for children at risk for out of home care OOHC.

All nine DCBS offices now have a CCSHCN nurse consultant residing in their office.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided nursing consultative services.	X		X	X
2. Conduct home visits in partnership with DCBS social workers.	X		X	X

3. Provide health education to foster families.	X	X	X	X
4. Provide case management services.	X	X	X	X
5. Establish and support a "medical home" in the Lexington regional office.	X		X	X
6. Establish and maintain the "medical passport".	X			X
7. Provide care coordination for all health care services.	X	X		X
8.				
9.				
10.				

b. Current Activities
The premise for establishing both the MFFC & Foster Care Support is routinely confirmed. Nurse consultants working with social workers significantly improves foster parents', biological parents' and social workers' understanding of the child's health issues and provides a significant level of constancy in maintaining health information for a very mobile population. Nurse Consultants' ability to assess conditions, instruct families about their child's condition, train families how to perform related necessary treatment or administer medication, and help families organize health information has enabled social workers to make better assessments about the child's well-being and safety. As a result SWs have been able to safely reunite families.

The Commission's information system, CUP, to used to collect the following data:
home visits, #referrals received, #consultations, # medical record/report reviews, #medical passports rev, #subspecialty refers., etc.

A primary care center was established in the Commission's Lexington office. This office was established to assure that primary care services would be available to the foster care population. A pediatrician and an ARNP have been hired.

c. Plan for the Coming Year
The CCSHCN plans to continue its collaboration with DCBS in teaming DCBS social workers with CCSHCN nurses to visit foster care children once a month to address their medical needs.

The Commission & DCBS are exploring ways to include children in kinship care. Currently consultation services are not available to this segment of the foster care population.

State Performance Measure 10: *Percentage of medically fragile foster children served by the Commission.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				30	45
Annual Indicator			5.6	85.7	78.1
Numerator			9	120	125
Denominator			160	140	160
Is the Data Provisional or Final?				Provisional	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55	65	75	90	80

a. Last Year's Accomplishments
The Commission and the Dept of Community Based Services (DCBS) continued exploring and developing how best to identify and respond to the health care needs of the medically fragile

foster children. Nurse Liaisons 1)interpret medical records, 2)serve as consultants to SWs and foster care families on medical issues 3) participate in monthly home visits for assessment purposes, 4)instruct foster families and SWs on medical procedures, treatments and expected outcomes, 5) assure establishment and maintenance of updated, current "medical passport" 6) enhance care coordination of all services, e.g. medical, dental and behavioral health 7) track the utilization of all health services, including prevention and wellness programs, 8) serve as consultants on medical issues for children at risk for out of home care OOHC.

All nine DCBS offices now have a CCSHCN nurse consultant residing in their office.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide nursing consultative services.	X		X	X
2. Conduct home visits in partnership with DCBS social workers.	X		X	X
3. Provide health education to foster families and social workers.	X	X	X	X
4. Provide case management services.	X	X	X	X
5. Establish and maintain the "medical passport".	X			X
6. Provide care coordination for all health care services.	X	X		X
7.				
8.				
9.				
10.				

b. Current Activities

CY: The Commission's information system, CUP, is used to collect the following data:
home visits, #referrals received, #consultations, # medical record/report reviews, #medical passports rev, #subspecialty refers., etc.

By utilizing nurse consultants coupled with an electronic health information system, children in the foster care system can be assured of a significantly improved health care delivery system as demonstrated in the following examples: A child diagnosed with lung and heart conditions 4 years earlier had received no follow up care. Neither the social worker nor the foster family was aware of the need for pediatric cardiology follow up services. As soon as a nurse consultant was assigned appointments with both a cardiologist and a dentist were scheduled, prophylaxis treatment was begun and the foster parents were instructed about the importance of treatment and assistance with coordinating the prophylaxis with the child's dentist was provided.

A foster child with abnormal newborn hearing screening results was referred to EHDI. Staffs were not told that the infant was place in foster care. If the child had not been referred to the MFFC program it would have been extremely difficult to track, monitor and follow up with the newborn hearing screening. Fortunately, however, once referred to the Commission the child's foster family was quickly identified and contacted, a follow up audiology exam was scheduled and the child was fitted with aids before 6 months of age.

c. Plan for the Coming Year

The CCSHCN plans to continue its collaboration with DCBS in teaming DCBS social workers with CCSHCN nurses to visit medically fragile foster care children once a month to address their medical needs.

State Performance Measure 11: *The number of Medicaid covered women who had at least one dental visit during their pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					28
Annual Indicator				27.3	32.3
Numerator				9588	11972
Denominator				35099	37053
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34	34	35	35	36

Notes - 2006
2006 data is preliminary and numbers could change.

a. Last Year's Accomplishments
The Kentucky Oral Health Program collaborates with community partners to improve the access to oral health care for pregnant women.

UK College of Dentistry: Centering Pregnancy with Smiles

The University of Kentucky College of Dentistry: Centering Pregnancy with a Smile is a new model to provide prenatal education and care for expectant mothers in small groups. The program has been developed and implemented at the Women's Health Center at the Trover Clinic in Madisonville, Kentucky and at the University of Kentucky. When fully implemented, over 1,000 women and their families will be included annually. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the new March of Dimes Program of the Kentucky Department for Public Health. Dr. Judith Skelton made a presentation about the Centering Project at the yearly March of Dimes Summit.

Consultation with Community Partnerships

The Kentucky Oral Health Program Administrator, epidemiologists, and health program administrator consulted with an Elizabethtown, KY collaboration (representatives of the local health department, hospital, dental providers, etc.) to establish an initiative to provide an oral health exam and necessary dental care to pregnant women being served by the local hospital and follow-up with the birth outcomes regarding a potential relationship with reduction of pre-term and/or low-birth weight infants in this initiative.

• The KOHP partners with the March of Dimes in their prematurity initiative.
• The KOHP encouraged dental screening and needed oral care for pregnant women in the Commonwealth.

In 2006, the UK College of Dentistry developed and implemented Centering Pregnancy with Smiles at the Women's Health Center at the Trover Clinic in Madisonville, Kentucky and at the University of Kentucky. The Centering Program provided prenatal education and care for expectant mothers in small groups. When fully implemented, over 1,000 women and their families were projected to be included annually. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the new March of Dimes Program of the Kentucky Department for Public Health.

Dental services provided were listed in the Kentucky Dental Services Fee

(http://chfs.ky.gov/NR/rdonlyres/FFEAD1C5-F94E-46EF-9E02-9C2CFB15F48D/15266/dental.pdf) and in accordance with 907 KAR 1:026, Section 2(1) and (2) (http://www.lrc.state.ky.us/kar/907/001/026.htm).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Kentucky Oral Health Program			X	X
2. Regional Dental Treatment Clinics, Primary Care Centers and local health department's oral health programs	X		X	X
3. Local Health department's prenatal programs	X		X	
4. March of Dimes, Johnson and Johnson Pediatric Institiute and Department for Public Health demonstration projects in 3 regions of the state.	X		X	X
5. HANDS home visiting program	X	X	X	
6. University of KY and University of Louisville Dental schools	X	X	X	X
7. Partnership with Medicaid and Medicaid Dental providers	X		X	X
8.				
9.				
10.				

b. Current Activities

The Kentucky Oral Health Program collaborated with community partners to improve the access to oral health care for pregnant women through the Centering Pregnancy with Smiles curriculum. These partners include: Frontier Nursing Services at Hyden, Kentucky, the UK Center for Rural Health at Hazard, Kentucky, the Women's Health Center located at the Trover Clinic in Madisonville, Kentucky and the UK College of Dentistry.

According to Medicaid preliminary data, approximately 32% of pregnant women eligible for Medicaid services received any dental services during FY 07-08. For the first six months of FY 07-08, there were 24,542 pregnant women eligible for Medicaid services, of those women, 5,758 received dental services. Per the Medicaid epidemiologists, past history would indicate the number of pregnant women and pregnant women receiving dental services will likely double by the end of the fiscal year. Dental services provided are listed in the current Kentucky Dental Services Fee (http://chfs.ky.gov/NR/rdonlyres/FFEAD1C5-F94E-46EF-9E02-9C2CFB15F48D/15266/dental.pdf) and in accordance with 907 KAR 1:026, Section 2(1) and (2) (http://www.lrc.state.ky.us/kar/907/001/026.htm).

c. Plan for the Coming Year

The Kentucky Oral Health Program will collaborate with the Kentucky Department of Public Health's Prenatal Program and Medicaid to provide materials and activities targeting both the public and health care providers regarding the importance of optimal oral health during pregnancy and throughout one's lifetime. Dental services listed in the FY 08-09 Kentucky Dental Services Fee will be provided through Medicaid.

The Kentucky Oral Health Program will continue to collaborate with community partners to improve the access to oral health care for pregnant women.

• The KOHP will continue to partner with the University of Kentucky College of Dentistry:

Centering Pregnancy With A Smile, located at the Women's Health Center at the Trover Clinic in Madisonville, Kentucky and at the University of Kentucky. The dental clinic will continue to provide dental service to women enrolled in the Centering Program. Data will be shared with partners for policy and funding issues.
• The KOHP will continue to encourage dental screening and needed oral care for pregnant women in the Commonwealth.
• The KOHP will continue to send copies of pertinent studies and educational material to a list serve of identified oral health contacts in the local health departments.
• Kentucky Medicaid will continue to provide the full mouth debridement for pregnant women enrolled in Kentucky Medicaid.
• The KOPH will continue to partner with the March of Dimes' prematurity initiative.

E. Health Status Indicators

HEALTH STATUS INDICATORS

Kentucky uses the Health Status Indicators for evaluation and monitoring of many of our MCH efforts. In providing information to the public, KY uses the HSI in combination with selected Healthy People (HP) 2010 goals to provide a context for the public to see how KY does in comparison to national goals. DPH adopted selected HP 2010 goals as Healthy Kentuckians 2010 goals in 2000, and recently has completed a Mid-Decade review and update of nearly 1000 measures and whether or not the state is making progress towards them. This is particularly useful during the legislative sessions, and does guide our direction in state public health efforts.

01A The percent of live births weighing less than 2,500 grams.
01B The percent of live singleton births weighing less than 2,500 grams.
02A The percent of live births weighing less than 1,500 grams.
02B The percent of live singleton births weighing less than 1,500 grams.

LBW and VLBW remain a problem in Kentucky.
The rate of LBW is increasing with the rate of preterm birth, but not as dramatically. In our data analysis, the rate of VLBW infant births has had little change over the last decade in Kentucky. In order to address LBW and VLBW, we are working on a number of programs: GIFTS smoking in pregnancy projects, preconception and interconception care emphasis in our health departments (teaching the Life Course Perspective Health Trajectory model from UCLA), Fetal & Infant Mortality Review, Guidelines for transfer of VLBW infants (Perinatal Task Force), and disparities initiatives such as Healthy Start and the proposal to establish the Office of Minority Health.

03A The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
03B The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.
03C The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.
04A The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
04B The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.
04C The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

Child Fatality and Injury prevention are a strong emphasis of the Division.
Several legislative bills deal with child safety with the booster seat bill being the most critical. It will be an issue until it passes. The booster seat bill is critical to the health and well-being of Kentucky's children ages 4-8. We are one of very few states who have not already passed a bill

to address this issue and will continue to provide data and information to support the passage of this important bill.

/2009/ After 7 years of advocacy by a number of groups, a Booster Seat Bill passed in the 2008 Kentucky General Assembly. Booster seats will be required for children age 7 and under and between 40 and 50 inches when riding in a vehicle. Courtesy warnings will be issued for the first year. We hope to persue raising the age to 8 when the opportunity arises. //2009//

Education is provided to parents, daycares and schools about the primary seat belt and graduated driver's licensing laws. Included in this education are court diversion programs. Several counties offer these as an option for those ticketed for not wearing seat belts/not having their child properly restrained. They pay a reduced fee and receive education on safety seat installation/importance of seat belt use. These funds buy car seats that are offered at a reduced price or provided free for families who cannot afford them. SAFE KIDS, Governor's Highway Safety Program, Drive Smart, local health departments, state police, Kentucky Pediatric Society, and others will use Child Passenger Safety Week to provide education on the importance of this issue. Efforts continue to train child passenger safety technicians. Education efforts continue to target parents, foster/adoptive parents, school nurses, grandparents, Commission for Children with Special Health Care Needs, hospitals, and child care providers.

The Department for Public Health has identified several target areas from the Healthy 2010 objectives for local health departments to choose as areas to work on in the areas of unintentional childhood injuries in the coming year. These include firearm safety, water safety, Safe Sitter training program, Safety seat use, restraint/seat belt use, helmet use, graduated driver licensing, Back to Sleep and Safe Sleep Environment for Infants. Public education and health promotion will continue to be vital strategies to any issue addressed at the local level that hopes to impact behavioral changes. Ninety percent of Kentucky county health departments will address at least one of these areas. In addition to local health departments, some counties have gone one step forward and applied to SAFE KIDS for money that will be used to provide car seat check up events, public education and other behavior changing activities in their communities. These counties are Bell, Madison, Estill, Christian, Hardin, and Metcalfe. Barren County functions as its own coalition and will continue extra activities as well.

05A The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.
05B The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.

Increases in Chlamydia

• The Infertility Prevention Program targets Chlamydia screening to women receiving family planning services and are between the ages of 15-24. Women above the age of 24 are screened if they are at increased risk, such as multiple sex partners, exposure to an infected partner, or history of a prior STD. All women who present to STD clinics are screened for Chlamydia.
• The amplified testing procedure that is currently utilized for Chlamydia detection is far more sensitive than prior procedures. As a result, more positive results are being found among persons tested. Consequently, increased reporting for Chlamydia has occurred.
• The time span between specimen collection and treatment date is currently being monitored to ensure timely treatment of infected individuals, which will stem the spread of disease.

F. Other Program Activities

Sexual Assault Prevention Program
Kentucky's first Rape Crisis Center began serving victims of rape and sexual assault in 1971. Today, 13 regional Rape Crisis Centers (RCCs) in Kentucky provide an array of sexual assault services to victims, their family members and friends. In addition to providing victim services, the RCCs provide an array of training and educational services throughout the state focused on risk reduction and awareness. The RCCs and their coalition, the Kentucky Association of Sexual Assault Programs (KASAP), have continued to honor the Cooperative Agreement with the Center for Disease Control and Prevention, Division of Violence Prevention that began in the fall of 2006.

The Sexual Violence Prevention Education (SVPE) funds (formerly known as the Rape Prevention and Education Program), have begun to incorporate primary prevention efforts aimed at ending the perpetration and victimization of sexual assault into their education programming. Efforts in the second year of this Cooperative Agreement have included the support of the Statewide Sexual Violence Prevention Planning Team (SVPT), a subcommittee of the Cabinet for Health and Family Services', Council on Domestic Violence and Sexual Assault. The SVPT has continued its comprehensive planning process based on the principles of Empowerment Evaluation and the 10 steps of Getting to Outcomes. Facilitated by the Statewide Capacity Building Team (SCBT) made up of the Cooperative Agreement coordinator, the Executive Director of KASAP, and Empowerment Evaluator from the University of Kentucky School of Social Work, the SVPT has collected and analyzed statewide data related to rape and sexual assault.

The result of this process was the establishment of draft target populations for the primary prevention focus of the participating RCCs. The following draft target populations were identified and will be further vetted for final selection: college-age persons (ages 18 -- 24), middle/high school persons (ages 11 -- 17), at risk families with children ages 4 -- 6), substance abusers and rural unreachables in economic distress. The establishment of further goals and objectives are also underway.

Funding from this Cooperative Agreement supports the continuation of the SVPT; supports the SCBT who continue to participate in the EMPOWER Cooperative Agreement with the CDC, Division of Violence Prevention; continues the training and technical assistance component being given to RCCs; and supports the establishment of an evaluation component which will include a plan for long term surveillance activities.

In addition to implementing a comprehensive planning component with this Cooperative Agreement, Kentucky's 13 RCCs and KASAP also continue to conduct the legislatively approved activities as a part of its comprehensive statewide SVPE Program with the emphasis on strategies that include primary prevention efforts.

The Department for Public Health is currently collaborating with Dr. Ann Coker to identify and secure funding and resources on Domestic Violence and Women's Health issues. Dr. Coker is the Professor and Verizon Wireless Endowed Chair in the Center for Research on Violence against Women at the University of Kentucky.

G. Technical Assistance

Request assistance to support state staff and one parent representative traveling to AMCHP and for state staff traveling to MCHB mandatory meetings. The Commission also requests funding to support a consultation from staff of the Healthy and Ready to Work National Center for the leadership team that is designing the Building Linkages to Transition (BLT) project.

Kentucky requests on-going technical assistance with the Needs Assessment process and

analysis. This will begin to build capacity and the skill sets necessary to conduct a comprehensive needs assessment.

Request continued technical assistance and consultation with the development and sustainability of a State FIMR project including assistance with training and facilitation of local FIMR projects.

V. Budget Narrative

A. Expenditures

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different than budget because of carryover and the varience of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistant within a given year. Any notes to explain variences have been attached to the financial form which they address.

For this reason, questions regarding specific financial activites should be relayed to the the Department for Public Health, Division for Administration and Finance; the Division responsible for financial reporting.

B. Budget

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provide as accurate information as is possible at that time.

Actual expenditures may also be different then budget because of carryover and the variance of grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes.

Generally speaking, budgeted and actual expended dollars have been relatively consistent within a given year. Any notes to explain variances have been attached to the financial form which they address.

For this reason, questions regarding specific financial activities should be relayed to the Department for Public Health, Division for Administration and Finance; the Division responsible for financial reporting.

Both the Division of Adult and Child Health Improvement and the Commission for Children with Special Health Care Needs will discuss FY06 budget within the section.

Division of Adult and Child Health Improvement, Department for Public Health

The vast majority of Title V Block Grant funding is allocated by the Division of Adult and Child Health Improvement to local health departments to support community programs that work toward attaining MCH performance and outcome measures.

In addition to MCH Title V funding, revenue from several major sources including other federal grants, KIDS NOW Early Childhood Initiative, KCHIP and Bioterrorism support local health departments.

Based upon the current estimated block grant allocations to Kentucky in FY06, (total of

$11,890,984) 34.9% or $4,149,953 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,741,031 will remain with the Department for Public Health.

For FY 06, the majority of this funding (93% or $7,234,570) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services.

Clinical service include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding is used to cover local health department clinical services.

Community Services implemented by local health departments include prenatal classes, oral health classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns; just to name a few. Approximately 10% of Title V funding is used to cover community services.

Special emphasis has been placed upon physical activity and nutrition services for youth. The combined use of all of the Preventive Services Block Grant and a portion of the Title V MCH Block grant is allocated solely to underwrite activities addressing the issue of inappropriate weight for height in Kentucky in children. As this performance measure is a primary health concern Kentucky's population, a combined use of these funds supports the intent of the block grant process; funding flexibility to address unique needs of states and communities.

In FY 05 funding to support prenatal care was designated for each county and health district; particularly for the uninsured and disparate populations. Program staff estimated that the costs of an uninsured birth are approximately $2,000 each. Hence, this sum was used to calculate allocations for Kentucky counties based upon historic needs. /2007/ This formula continues to be used for FY 06. //2007//

Below is a listing of how Kentucky's local health departments are using Title V funding during FY05. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712)Dental Clinical Services $4,316 (<1%)
(CC 800)Pediatric Well-Child $2,367,955 (31%)
(CC 802)Family Planning $1,259,505 (16.5%)
(CC 803)Maternity $1,338,835 (17.6%)
(CC 805)Nutrition $1,627,115 (21.4%)
(CC 852)Resource Persons $1,334 (<1%)
(CC 818)Community Activities $867,064 (11.4%)
(CC 857)Physical Activity $152,867 (2%)

Total $7,618,991

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, child preventative, adult personal health and medical nutrition therapy), allocations for individuals programs may vary depending upon community need as determined by a local needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health objectives. The Title V Administrator works with the budget review team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities.

The Commission for Children with Special Health Care Needs receives 34.9% of the Title V Allocation which, in FY06, will amount to $4,149,953.

Additionally, capacity building costs for ACHI underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville. Funding has also been allocated in FY 06 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel($30,000). A new project is the Infant Mortality Project in Louisville Metro ($20,000).

Finally, some infrastructure costs for the Department for Public Health are underwritten by Kentucky's Title V Block Grant. This included a portion of the cost of Kentucky's local health department billing and services reporting system, Patient Service Record System (PSRS).

/2007/ Based upon the current estimated block grant allocations to Kentucky in FY07, (total of $11,496,808) 34.9% or $4,012,386 will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,484,422 will remain with the Division of Adult and Child Health Improvement.

For FY 07, the majority of this funding (91% or $6,823,304) will be re-allocated through a block grant process to local health departments. Local health departments have the ability to select particular cost centers in which to use this funding. Additionally, they may use it for clinical (personal health) or community (population-based) services. Approximately 14% of Title V funding was used to cover community activities in FY 06.

Below is a listing of how Kentucky's local health departments are using Title V funding during FY06. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712)Dental Clinical Services $10,918 (<1%)
(CC 800)Pediatric Well-Child $1,725,817 (24%)
(CC 802)Family Planning $1,758,421 (24.3%)
(CC 803)Maternity $1,182,248 (16.3%)
(CC 805)Nutrition $1,083,775 (15%)
(CC 852)Resource Persons $575 (<1%)
(CC 818)Community Activities $990,413 (13.7%)
(CC 857)Physical Activity $482,403 (6.7%)

Total $7,234,570

Additionally, capacity building costs for DPH underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Training) with the University of Louisville that will continue in FY 07. Funding has also been reallocated in FY 07 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel ($30,000). The infant Mortality Project in Louisville is now being funded with State General Funds. //2007//

/2008/ Below is a listing of how Kentucky's local health departments are using Title V funding during FY07. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712) Dental Clinical Services $64,529 (1%)
(CC 800) Pediatric Well-Child $1,918,725 (28.2%)
(CC 802) Family Planning $1,665,051 (24.4%)
(CC 803) Maternity $1,120,394 (16.4%)
(CC 805) Nutrition $1,009,349 (14.8%)
(CC 818) Community Activities $695,839 (10.2%)
(CC 857) Physical Activity $334,676 (4.9%)

Total $6,808,563

Additionally, capacity building costs for DPH underwritten with Title V Funding include portions of two program contracts (Maternal Mortality Review and Public Health Pediatric Training) with the University of Louisville that will continue in FY 08. Fetal and Infant Mortality Review is being added to this contract to develop a statewide FIMR project. Funding has also been reallocated in FY 08 to continue to support the Mental Health/Mental Retardation Suicide Prevention personnel ($15,000). This contract was reduced when the Department of Mental Health Mental Retardation received a $400,000 grant for Youth Suicide Prevention.

For the KIDS NOW Early Childhood Programs funded through the Department of Education Tobacco Settlement Funds for FY 08.

Name	Amount
HANDS	$10,000,426
Reach Out and Read	$250,000
Healthy Start in Child Care	$1,180,719
Immunization for Underinsured	$2,017,950
Folic Acid	$424,366
Early Childhood Mental Health	$882,511
Early Childhood Oral Health	$377,018
KEIS	$1,000,000
TOTAL:	$16,132,990

//2008//

/2009/ Due to a delay in state budget allocations, the local health department plan and budget process was not complete at the time of grant submission. Thirty-four percent of Title V funding will be allocated to the Commission for Children with Special Health Care Needs. The remaining funds will remain with the Department for Public Health. The majority of the remaining funding will be used for allocations to local health departments for clinical and community services including Oral Health, Pediatric/Well Child Services, Family Planning, Maternity Services, Medical Nutrition Therapy, Physical Activity and Health Education. Other funding will Suicide Prevention, Fetal and Infant Mortality Review, Maternal Mortality Review, Pediatric Clinical training, CDP Billing and Reporting system, Title V staff and travel. //2009//
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Commission for Children with Special Health Care Needs

The Commission anticipates the FY05 budget to include state and agency funds in excess of the 1989 maintenance of effort level. State and agency funding is expected to remain above the 1989 maintenance of effort level of $8,170,428 for the foreseeable future.

In addition to MCH Title V Block grant dollars, the Commission's primary source of funding are State dollars (mix of state general funds and Tobacco Settlement funds) and Agency funds. The agency revenues are receipts from third party billings for direct patient care and care coordination. The Commissions' budget for FY05 is projected as follows: State General funds $6,205,000, Tobacco Settlement Funds $555,000, and Agency Funds $4,890,100. Other Federal sources of funding in the FY05 budget include CDC grant/University of North Carolina ($66,000); MCHB/Wake Forest University ($40,000); Sound Start (EHDI) Grant $126,000.
/2008/ FY08 includes Tobacco Settlement Funds $352,000, Agency Funds $4,008,100, CDC grant $67,000, and KISS grant $125,000. //2008//

/2009/ The fiscal condition the Commonwealth of Kentucky faces over the next two years is unprecedented, with projected revenues in both years of the next biennium significantly below current spending levels. To address the structural imbalance state agencies were required to reduce state funding. The Commission for Children with Special Health Care Needs reduced state and agency funds by 3% for fiscal year 2008. The budget for the biennium 2009-2010 required additional budget reductions. Key components to reducing operating expenses on a reduced budget base include:

•Reduction of state workforce through attrition. All hiring actions must be justified as essential to the delivery of services and that funds are available to sustain the position within the reduced budget.

•Review All Contracts for Cost Savings. All new contracts must be justified as essential to the delivery of services and must demonstrate that the service cannot be provided with existing personnel.

•Reduce Travel Expenses.

•Reduce printing Costs.

•Curtail Equipment and Furniture Purchases. A moratorium is placed on all purchases of furniture and equipment by state agencies.

Summary

While the budget for the state is austere, the budget for the Commission will be sufficient to continue services at current levels. This is far better than most state agencies; however it will require the Commission to operate on a bare bones budget. The Commission will be slow in filling positions, and all vacancies will need to be strongly justified. All expenses, from office supplies to furniture to equipment, will need to be justified. This will not be an easy time, but one that (barring a big downturn in the economy or some other statewide fiscal crisis) we should be able to continue services without interruption. //2009//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.